The California Department of Alcohol and Drug Programs
The California Department of Mental Health

Co-Occurring Disorders Workgroup

Final Report

March 2, 2004

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EXECUTIVE SUMMARY

The Co-Occurring Disorders Workgroup (COD Workgroup) strongly recommends a comprehensive approach to clinical and administrative improvements that supports coordination/integration of substance abuse and mental health services for persons with co-occurring disorders. Such an approach is one in which training, financing, licensing and certification requirements, and corresponding data/outcome measurement requirements are aligned. Training on best practices alone will not produce results if the infrastructure, financing, licensing, or reporting requirements of the two fields are not consistent and do not support implementation of coordinated/integrated practices. The Workgroup believes that this comprehensive approach to addressing co-occurring disorders includes, but is not limited to, the following:

- Best and promising practices based on the best available evidence and supported through technical assistance, funding, contracting, and other mechanisms.
- Exploration of innovative funding alternatives that promote and support coordinated/integrated services.
- Inter-disciplinary teams, that may be interagency, to promote and ensure a coordinated/integrated approach.
- Training and technical assistance to support the development and refinement of the resulting comprehensive system of care for persons with co-occurring disorders.

For purposes of this report and for this Workgroup, the phrase “co-occurring disorders” refers to substance abuse and mental disorders that affect an individual simultaneously. Debate regarding terminology resulted in agreement for a seminal recommendation by the COD Workgroup that may be summarized as one team with one plan for one person:

- Use the term “coordinated/integrated” services to describe the approach for persons with co-occurring disorders.
- Define coordinated/integrated services as “all necessary services and support delivered by a single service team which has all the needed skill sets to develop and follow one client-centered plan that focuses on recovery and the individual person’s goals and strengths.”

By crafting this definition the COD Workgroup wants to emphasize the necessity of joint efforts between the alcohol and other drug (AOD) and mental health (MH) fields to deliver services to individuals with co-occurring disorders, rather than to recommend consolidating the fields or diminishing the autonomy of either one.

Focal Populations

Five focal populations were identified. The COD Workgroup recommends that the statewide effort to improve services for persons with co-occurring disorders in California begin with these groups, not ranked in priority order:

- Pregnant women and parents with co-occurring substance abuse and mental health problems.

- Indigent adults with co-occurring substance abuse and mental disorders who also experience frequent or long-term health crises or homelessness.
- Individuals involved with the criminal justice system who have co-occurring disorders.
- Adults with serious mental illness and a substance abuse disorder.
- Children and youth with serious emotional disturbance and a substance abuse disorder.

There are a wide variety of people with a broad range of needs and some of the focal populations are particularly complex and vulnerable. The COD Workgroup believes resources to assist them could be better coordinated and then produce improved outcomes if funding to support needed treatment were appropriately aligned.

Five key short-term recommendations emerged as opportunities for the California Department of Alcohol and Drug Programs (ADP) and the California Department of Mental Health (DMH) for noticeable impact both in the field and on the clients that would improve the existing system of care for persons with co-occurring disorders. These short-term recommendations for immediate implementation are that ADP and DMH should take the following actions:

1. **Policy Statement** – Issue a joint, interagency policy statement confirming their commitment to, and expectations for, treatment for persons with co-occurring disorders. The statement should clearly identify the impropriety of excluding persons with co-occurring illnesses from either treatment system or from other similar service systems.

2. **Program Licensing and Site Certification** – Convene an ongoing specialty workgroup of licensing and certification experts from all relevant state departments and providers to (1) articulate a comprehensive framework for program licensing and site certification, and/or standards for programs that are exempt from these requirements, to address the full range of program models with demonstrated effectiveness for persons with co-occurring disorders; (2) develop standards for addressing other mental disorders within substance abuse programs; (3) clarify mechanisms for removing regulatory barriers that discourage providers from serving this population; (4) create incentives for development of co-occurring disorders programs through adequate reimbursement, based on meeting licensing and site certification standards.

3. **Universal Chart Format** – Develop a universal chart format/medical record and a single audit protocol for treatment record documentation. Policies and procedures that have been developed relative to combined file formats will need to be clarified and re-disseminated.

4. **Outcomes** – Identify overlapping or shared data between current AOD and MH data sets as a first step in the development of a single set of specific outcomes to be collected for individuals receiving substance abuse and mental health services for co-occurring disorders. A diagram of this overlapping system is shown in Appendix C (The Universal Chart for Addiction and Mental Health Treatment, Peter Banys, M.D.). Outcomes reporting should be streamlined and outcomes measurement requirements aligned with co-occurring disorders program goals. A common/single set of measures, defined consistently, should be established to determine practical outcomes of policy significance in the areas of physical and behavioral health, safety, economic well-being,

criminal justice involvement or avoidance of such involvement, and education and workforce readiness or participation of individuals with co-occurring disorders.

5. **Training Committee** – The COD Workgroup formed a Training Committee composed of three expert psychologists familiar with co-occurring disorders who have mapped out a staff training plan with distinct action steps. This includes a Train-the-Trainers component to create a pool of teaching staff that can offer didactic presentations, skill practice sessions, clinical supervision, and consultation around the state. When possible, training activities should be synchronized with changes in other related areas, such as endorsement of integrated assessments for co-occurring disorders at program sites, staff evaluation on the basis of increasing proficiency in addressing co-occurring disorders, and other systemic elements that reinforce new skill acquisition. Public recognition of staff progress and achievement should be encouraged. The COD Workgroup also reviewed and endorsed the training plan proposal included in Appendix B of this report.

In order to develop a comprehensive approach to services, long-term recommendations that ADP and DMH should undertake include:

1. Best and Promising Practices

   - Collaborate with research institutions and federal and state agencies to conduct further investigation of emerging, evidence-based practices for persons with co-occurring disorders; and, as they emerge, continue review of California-based and other best practices for the implementation of evidence-based and other promising practices for each of the focal populations.
   - Based on best and promising practices, refine specific outcomes to be collected by treatment and service programs for individuals receiving substance abuse and mental health services for co-occurring disorders to further these best practices and services.
   - Collect key data elements to measure the effectiveness and efficiency of service interventions specific to the co-occurring disorders populations.
   - Streamline existing data collection. Design and augment other outcome measures identified by the COD Workgroup that could be added to the California data sets to create a group of well-supported, shared indicators.
   - Expand promising programs that have demonstrated success in serving persons with co-occurring disorders.

2. Funding Alternatives

   - Request that the Legislative Analyst's Office conduct an analysis of the costs of co-occurring disorders to the State or to local governments, particularly those that are attributable to the current limited availability of effective treatment and support for co-occurring disorders clients.
   - Establish an ongoing workgroup to explore further and determine more definitely the feasibility of funding opportunities identified by the COD Workgroup.
   - Further explore and determine the feasibility of funding opportunities identified by the COD Workgroup here, as well as those that may emerge.

- Optimize federal funding for the five focal populations identified.
- Identify funding gaps, barriers and the means to overcome barriers, and identify additional funding sources and ways to overcome barriers to using them.

3. Partnerships to Promote Coordinated/Integrated Services

   - Establish formal linkages among ADP, DMH, and the California Departments of Corrections, Health Services, and Social Services to address systemic barriers for services and relevant entitlements such as Medi-Cal for persons with co-occurring disorders.
   - Work to establish formal linkages among county AOD and MH agencies to develop similar coordinated/integrated service approaches, training, and protocols with appropriate attention to specific privacy, confidentiality, and administrative coordination requirements.

4. Effective and Ineffective Practices

   - Partner continuously to support the adoption and expansion of effective practices and the replacement of ineffective practices, based on the best available evidence.
   - Pursue available grant funding through the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Infrastructure Grants and/or its Best Practices Planning and Implementation Grants or other sources.

5. Public Sector Outcomes and Performance Measures

   - In concert with federal agency guidelines and initiatives, the State and public sector need to be held accountable to document that they deliver validated forms of care, as evidenced by meaningful mental health and substance-related outcomes data gathering efforts appropriate to the co-occurring disorders population.

Given the State's current fiscal environment and the imperative need to implement improvement in services provided to those with co-occurring disorders by reinventing service approaches in line with best practices, the next steps that the COD Workgroup recommends to APD and DMH are to issue expeditiously the interagency joint policy statement to confirm the Departments' commitment to working collaboratively to reduce administrative barriers and support coordinated/integrated services for clients with co-occurring disorders.

Having sought and received extensive feedback from SAMHSA on California's 2003 co-occurring disorders grant application, California should re-apply for a Co-Occurring Disorders State Incentive Grant, demonstrating that it continues to focus on the growing problem of co-occurring disorders. The strong collaboration demonstrated by this COD Workgroup, the continued focus of the members and the Departments on providing effective services to the diverse populations that comprise California, and the advent of the new administration in Sacramento can combine to produce a viable, competitive grant application in 2004. The Departments should also continue to pursue other resource opportunities aggressively to provide funding to address both short-term and long-term recommendations.

THE CO-OCCURRING DISORDERS WORKGROUP

Introduction: Workgroup Composition and Purpose

In October 2002, the Directors of the California Departments of Alcohol and Drug Programs (ADP) and Mental Health (DMH) established the Co-Occurring Disorders Workgroup (COD Workgroup) to recommend strategies to improve treatment outcomes for persons with co-occurring disorders. Each Department selected six members to participate on the statewide COD Workgroup. A representative of the California Department of Corrections (CDC) was invited to participate; and after the initial meeting, the COD Workgroup successfully requested that representation be added from the California Department of Health Services (DHS) and the California Department of Social Services (CDSS).

The COD Workgroup, which included a psychiatrist, several psychologists, county administrators, executive directors of treatment provider organizations, program directors and policy professionals, was a 13-member committee with membership also representing the County Alcohol and Drug Program Administrators Association of California (CADPAAC) and the California Mental Health Directors Association (CMHDA), as well as nationally-recognized professionals with multiple expertise in the fields of behavioral health, treatment, housing, financing, and criminal justice.[1] A roster of COD Workgroup members is included as Appendix A.

The four primary tasks assigned to the COD Workgroup by the ADP and DMH Directors were to:

1. Identify the best/most promising practices from the demonstration projects funded under the earlier Dual Diagnosis Task Force and other state and national sources for broader dissemination.

2. Identify funding alternatives, both current and emerging, for extending best practices.

3. Propose potential partnerships to promote coordinated services at the state and local levels.

4. Propose training and technical assistance mechanisms to support local community capacity building.

The COD Workgroup is committed to expanding upon and not duplicating recent state and federal initiatives in co-occurring disorders. As much as possible, members reviewed research articles and state and federal publications/reports to set guiding values and direction for the COD Workgroup. During the months in which the group met, several other state and national commissions released important reports which addressed issues that were considered by the group. Their findings and recommendations were frequently consistent with the perspectives of the COD Workgroup.

Major reports reviewed by the COD Workgroup, which also provided key background, analysis, and recommendations for strengthening systems which provide treatment and support to persons with co-occurring disorders include, but were not limited to, the following:

- California Department of Mental Health/California Department of Alcohol and Drug Programs, "Final Report: Dual Diagnosis Demonstration Projects" (June 2002)
- Little Hoover Commission, "For Our Health and Safety: Joining Forces to Defeat Addiction" (March 2003)
- Substance Abuse and Mental Health Services Administration, "Strategies for Developing Treatment Programs for People with Co-occurring Substance Abuse and Mental Disorders" (March 2003)
- President's New Freedom Commission on Mental Health, "Interim Report of the President's New Freedom Commission on Mental Health" (November 2002) and "Achieving the Promise: Transforming Mental Health Care in America" (July 2003)[2]

Statement of Goals and Guiding Values

There is no "wrong door" – wherever a person enters treatment is the right place.

The COD Workgroup has developed a shared vision of a comprehensive system of care for persons with co-occurring disorders. Based on national statistics, there is strong agreement that due to the prevalence of co-occurring disorders, a person entering the treatment system with co-occurring disorders should be accepted by the system as the norm, rather than the exception. The group recognized that many of the individuals seeking treatment in either the alcohol and other drug (AOD) or mental health (MH) systems have co-occurring disorders and the treatment system should be prepared to effectively address all of the needs of each co-occurring disorders individual. The COD Workgroup further recognized that many persons with co-occurring disorders are not accessing the treatment system(s), and that unmet need for co-occurring disorders treatment and support often results in added costs to other systems including, but not limited to, the State's already stressed medical and psychiatric emergency rooms and jails.

The COD Workgroup identified four major goals from their goals and guiding values:[3]

1. **Person-Centered Initiatives** – Each person with co-occurring disorders receives services and support tailored to his/her own unique situation and needs so that he/she may become as productive as possible. These person-centered initiatives include:

    - Persons with co-occurring disorders can easily access help to address their needs, build upon their strengths, and achieve their goals. There is no "wrong door" – wherever a person enters treatment is the right place.

    - While respecting confidentiality, service providers and others involve the individual and his/her support system in the process of determining service plans, and provide coordinated and comprehensive information, services, and resources that support recovery.

- Persons with co-occurring disorders are treated with respect in every encounter they have with the AOD, MH, health, education, criminal justice, and social service systems to reduce existing barriers and stigma, increase viable treatment engagement and retention, and increase the likelihood of positive outcomes.

- Persons with co-occurring disorders who are in transition-age groups between child and adult services (18-25 years old) obtain targeted, individualized assistance so that their unique needs are adequately addressed in treatment systems.

- Persons with co-occurring disorders who are members of racial or ethnic minority groups, and/or homeless, or of very low income receive care sensitive to their special needs, and it is of a quality standard that is clinically appropriate and comparable to all individuals with such disorders.

2. **Service Coordination / Integration** – The county and other service systems for persons with co-occurring disorders should also embrace a commitment to service coordination/integration. Regardless of the funding source or affiliation of the team members, all necessary services and support should be delivered by a single interdisciplinary service team that has all of the needed skill sets and the right participants, focusing on the given individual. This team will provide services according to one service/support plan that focuses on the person's goals for recovery:

...all necessary services and support should be delivered by a single interdisciplinary service team that has all of the needed skill sets and the right participants, focusing on the given individual.

   - The county AOD and MH agencies and their partners create incentives to reinforce service coordination/integration and a seamless service delivery system.
   - County AOD and MH agencies and their state, county, and local community partners focus on administrative and operational enhancements to optimize sharing of information, resources, and best practices, while protecting the privacy rights of co-occurring disorders service recipients.
   - The county service system and the eligibility requirements for persons with co-occurring disorders are flexible and respond to the service needs and demands for both the countywide population and specific population groups of those who experience co-occurring disorders.
   - State, county, and municipal service systems that coordinate/integrate on behalf of persons with co-occurring disorders respect individuals' specific problems and ethnic identities and use evidence-based practices to coordinate most effectively on their behalf.

3. **Evidence-Based Practices** – In this report, evidence-based practices (EBPs) refer to a menu of evidence of graduated scientific rigor, with randomized, controlled studies being the highest level of proof and consensus panels and expert clinical opinion as a second most documented type of evidence identifying best practices. The COD Workgroup recognizes a broad definition of EBPs, as does the federal Substance Abuse Mental Health Services Administration (SAMHSA)/Department of Health and Human

Services, because of a concern that in substance abuse and mental health there have been limited funds to invest in the most rigorous forms of research to validate promising treatment approaches that have demonstrated effectiveness for persons with co-occurring disorders.[4] The results of accomplishing this goal will be:

- Services for persons with co-occurring disorders will be based on valid research or consensus-tested practices that demonstrate positive outcomes for clients and their communities. Research findings may issue from rigorous, randomized field trials, or from contemporary expert consensus panels and quasi-experimental studies, and from program and policy evaluations prepared for policymakers and other key constituencies.
- The public service system for persons with co-occurring disorders will be committed to evidence-based, innovative service delivery and administrative practices for co-occurring disorders clients, and to evaluating the effectiveness of new and emerging practices as a component of continuous quality improvement.

4. **Outcomes Data Collection** – The public service system for persons with co-occurring disorders is committed to the disciplined pursuit of results and accountability across systems. Specifically, any strategy designed to improve the public system of care for persons with co-occurring disorders should ultimately be judged by whether it helps achieve better, more meaningful, and practical outcomes for service recipients and tax payers in the areas of health, safety, economic well-being, social and emotional well-being, education, and workforce readiness.

OVERVIEW OF RECOMMENDATIONS

The COD Workgroup strongly recommends a comprehensive approach to clinical and administrative improvements that support coordination/integration of services. Such approaches are those in which training, financing, licensing and certification requirements, and data/outcome measurement requirements are aligned with one another and as a whole package. Training on best practices alone will not produce results if the infrastructure, financing, licensing, or reporting requirements are inconsistent with this goal and cannot support implementation of those practices. A comprehensive approach to addressing co-occurring disorders includes the following recommendations:

- Implement The Vision: One Team with One Plan for One Person
- Develop a Joint Policy Statement by California Departments of Alcohol and Drug Programs and Mental Health
- Initiate and/or Reinforce Partnership and Collaboration to Promote and Provide Co-Occurring Disorder Services
- Identify Focal Populations as a Strategy to Move Forward within Limited Resources
- Identify and Pursue Funding Alternatives
- Develop and Implement a Training Plan
- Develop Standards for Program Licensing and Site Certification that Address the Needs of Individuals with Co-Occurring Disorders
- Develop a Universal Chart
- Identify and Adopt Effective Practices
- Identify and Discontinue or Modify Ineffective Practices
- Specify and Use Public Sector Outcomes and Performance Measures

RECOMMENDATIONS

Implement the Vision: One Team with One Plan for One Person

COD Workgroup discussion regarding terminology resulted in agreement on a seminal recommendation that may be summarized as one team with one plan for one person:

- Each individual receives a comprehensive assessment that results in the formation of an interdisciplinary and possibly interagency team that will develop an individualized treatment plan for that person within a reasonable period of time. One agency will serve as lead agency for that person and will coordinate/meet with other team members to reach resolution on a unified plan to address that person's issues, needs, and identity.
- This plan will specify all necessary services and supports to be delivered by the single interdisciplinary service team that has all the needed skill sets and the right members in place from each agency.
- The individual client will have a strong voice in shaping the plan in development and implementation. The plan is expected to evolve as needed as that person progresses.

Develop a Joint Policy Statement by California Departments of Alcohol and Drug Programs and Mental Health

ADP and DMH should develop a joint policy statement that will focus on specific statewide issues relevant to co-occurring disorders that impact the AOD and MH fields and limit the effectiveness and efficiency of treatment. This policy statement will provide guidance in reducing administrative barriers and in supporting the field to provide coordinated/integrated services to persons with co-occurring disorders. The policy statement will be guided by various reports such as the "Co-Occurring Disorders Workgroup Final Report," "Final Report: the Dual Diagnosis Projects," the Substance Abuse and Mental Health Services Administration's "Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Health Disorders," and "Achieving the Promise: Transforming Mental Health Care in America" by the President's New Freedom Commission on Mental Health.

Initiate and/or Reinforce Partnership and Collaboration to Promote and Provide Co-Occurring Disorders Services

The COD Workgroup strongly supports ADP and DMH contacting other relevant state agencies to initiate and/or reinforce collaborative partnerships among state departments and begin to address co-occurring disorders and integrated/coordinated services at the state level. In addition, the COD Workgroup recommends that ADP and DMH encourage a commitment to the development of coordinated/integrated services for the co-occurring population at the county and municipal levels in California.

At the state level, this collaborative partnership would logically include, but not be limited to, representatives from ADP, DMH, DHS, CDSS, the Department of Housing and Community Development, the Department of Education, and the Youth and Adult Correctional Agency. Either initially or as the effort matures, the partnership may expand to include other departments and agencies, as necessary and appropriate, such as the Employment Development Department, to promote evidence-based and culturally appropriate service approaches for the numerous, ethnically diverse persons with co-occurring disorders.

> ...providing competent, efficient, and effective services for the co-occurring disorders population requires the inter-departmental and interagency collaboration discussed here...

Interagency cooperation in California has already been amply demonstrated on behalf of Substance Abuse Crime Prevention Act of 2000 (Proposition 36) clients, as well as individuals involved in the existing focused systems of care for individuals with a serious mental illness, including children. Thus, both ADP and DMH have positive experience in this regard. In another good example of cooperation and partnership, CDC, which could well be another partner agency for co-occurring disorders services, has recently automated the Social Security Administration's Supplemental Security Income (SSI) forms in a database so that criminal justice caseworkers can complete the forms prior to parolees' release and ensure that these individuals have income support to prevent re-incarceration. Working with the Social Security Administration, CDC is currently piloting the project in select areas across the state before implementing the new automated system statewide. Other recent California initiatives that provide excellent models of interagency cooperation include the former Governor's Interagency Task Force on Homelessness. The COD Workgroup believes that the public sector has ample experience in making interagency coordination and cooperation work effectively and that the State can draw upon this strong experience to assist persons with co-occurring disorders more effectively.

Service Coordination and Integration Requires Partnership and Effective Collaboration

The COD Workgroup suggests that providing competent, efficient, and effective services for the co-occurring disorders population requires the interdepartmental and interagency collaboration discussed here, especially common service forms and common therapy development on behalf of these numerous individuals.

Service Coordination and Partnership are not Simple Objectives

As noted above, ADP and DMH already have examples of program or population-focused efforts that have required coordination, collaboration, and effective partnership and service development with one another and with other agencies; but the efforts have typically dealt with smaller, more focused target populations and have often been special efforts related to the requirements of a particular grant. Broader and more sustained collaboration is possible but not yet typical, nor has it become a permanent feature at the state, county, or municipal levels. It requires nurturance and support from ADP and DMH, as well as the counties, as well as further training of practitioners and agencies in cooperative practices.

SPECIFIC RECOMMENDATION:

- Establish formal linkage among ADP, DMH, CDC, DHS, and CDSS to address systemic barriers to services and relevant entitlements such as Medi-Cal for persons with co-occurring disorders.

- Work to establish formal linkages among county AOD and MH agencies to develop similar coordinated/integrated service approaches, training, and protocols, with appropriate attention to specific privacy and confidentiality and administrative coordination requirements.

Barriers

Service, funding, and eligibility silos continue to be part of public sector infrastructure. Outside of particular grants, such as those that support the Children's System of Care Initiative in DMH, agencies that serve individuals in the AOD, MH, and/or the co-occurring disorders population lack effective and consistent strategies for working together across agency boundaries and routinely, systematically, and effectively involving the other relevant agencies. One of the challenges in providing services for persons with co-occurring disorders will be to build collaborative interagency relationships that are sustained and support the coordinated/integrated services needed by this large and increasing population of persons in need of improved services.

SPECIFIC RECOMMENDATION: Establish formal linkages among ADP, DMH, CDC, DHS, and CDSS to address systemic barriers to services and relevant entitlements such as Medi-Cal for persons with co-occurring disorders.

SPECIFIC RECOMMENDATION: Work to establish formal linkages among county AOD and MH agencies to develop similar coordinated/integrated service approaches, training, and protocols, with appropriate attention to specific privacy and confidentiality and administrative coordination requirements.

Identify Focal Populations as a Strategy to Move Forward within Limited Resources

Because the COD Workgroup recognizes that California is in a fiscal situation that makes finding additional state funds unlikely this year or next, and because the co-occurring disorders population is growing in California and nationally at the same time, the COD Workgroup believes it would be important to identify the most costly, most recidivistic, and most complex populations for implementation of coordinated/integrated co-occurring disorders services, so that the greatest level of savings and most needed enhancements from improved services could be realized as soon as possible. Among persons with co-occurring disorders, there are distinct subpopulation groups that can be characterized by age, gender, degree of disability, involvement with the criminal/juvenile justice system, and other special needs or circumstances. The COD Workgroup identified five "focal populations" whose characteristics especially reflect a heightened need for coordinated/integrated behavioral health care, as well as being subject to the otherwise excess costs and poor outcomes that result from current fragmented clinical and funding approaches.

The "focal populations" listed below are examples of groups that are often found to have high rates of co-occurring disorders and that also have some designated funding available to them now that could possibly be optimized. The groups listed below are not exhaustive of all possible persons who could greatly benefit from co-occurring disorders services. They are more likely to have primary diagnoses of serious mental illnesses complicated by substance abuse disorders than to have primary diagnoses of substance abuse, coupled with mental health disorders. Overall, substance abuse funding has been less than mental health funding, except for appealing groups such as pregnant, addicted women. The examples below are provided with these limitations in mind, but they do offer the state opportunities that the COD Workgroup felt were important to identify. The list below should be understood to be:

1. Not exhaustive of all possibilities;
2. Examples only;
3. Not listed in order of any priority; and
4. Not necessarily the particular groups that one might prioritize in a given community, especially if that community departs from the pattern below by being one that suffers from high rates of primary substance abuse complicated by mental health disorders.

To identify each of the focal populations listed, the COD Workgroup considered the issues of:

- The primary source(s) of funding available to provide treatment and support, and the populations for which there appear to be the greatest opportunities to optimize the primary or secondary funding source(s).
- The most serious current gaps and/or challenges that could be addressed with coordinated/integrated care models.
- Potentially avoidable costs and ineffectiveness associated with the limited (or absent) availability of evidence-based treatment and support.
- Potential sources of funding or strategies for more effective investments to close identified gaps for these focal populations.

- The potential for achieving cost-offsets or savings that could be available and subsequent reinvestment to increase the availability of more effective treatment and support for these groups of people with co-occurring disorders.

California's statewide efforts to improve systems that finance and deliver treatment and client support should begin with a focus on these groups. In particular, the State should take steps to remove obstacles or disincentives to align administrative requirements and funding to facilitate the delivery of more effective, coordinated/integrated treatment and support for each of these focal populations. Specific strategies will need to be adopted for each of these focal populations or any others identified because of important differences in the populations' service needs and eligibility for categorical funding. Within each focal population, there will also need to be substantial consideration of adjustment or development of specific approaches to California's exceptional cultural diversity and to the fact that co-occurring disorders seriously affect low income, special needs minority residents, some of whom are also non-English-speaking.

> ...the State should take steps to remove obstacles or disincentives to align administrative requirements and funding...

The COD Workgroup emphasis on these "focal populations" is not meant to imply a recommendation that care for any one or more of these groups should become the highest priority for allocating limited resources from either the AOD or MH treatment systems, or that either system should exclusively focus on one or more of these target populations. It should be acknowledged that the MH system currently identifies persons with serious mental illness (SMI) and serious emotional disturbance (SED) as their primary target populations, while the AOD system does not specify a target population for service allocation purposes. The COD Workgroup explicitly acknowledges that each system may also recognize other priority populations, and that some local communities may identify higher priorities based upon local factors that have a significant impact on community residents and systems.

The focal populations identified are:

> ***SPECIFIC RECOMMENDATION***
> - Begin with five focal populations
> - Services at the state and county levels should be collaborative
> - Culturally and racially diverse individuals are particularly vulnerable and have complex needs
> - Current fragmented approaches could be better coordinated and produce improved outcomes
> - Adequate funding is required to support needed treatment alignments with best practices

- **Pregnant women and parents with co-occurring substance abuse and mental health problems** – This group includes pregnant women or parents who have a substance abuse problem and a mental health condition which seriously interfere with family stability, child well-being, and/or participation in work or welfare-to-work activities. It may include individuals who are participating in the California Work Opportunity and Responsibility to Kids (CalWORKs) program.
- **Indigent adults with co-occurring substance abuse and mental disorders who also experience frequent or long-term health crisis or homelessness** – This group includes adults with substance abuse and mental health problems who also experience frequent acute or long-term psychiatric or medical emergencies, serious

health conditions (e.g., HIV/AIDS), and/or long-term or recurrent episodes of homelessness. This group also includes indigent adults who often have long-term substance abuse problems, but are only episodically diagnosed with SMI that exacerbates or is exacerbated by substance abuse, other health conditions, and/or homelessness.

- **Individuals involved with the criminal justice system who have co-occurring substance abuse and mental disorders** – This group includes a growing number of adults with co-occurring substance abuse and mental disorders who are involved with, or are being discharged or diverted from the criminal justice system, including parolees and others being discharged or diverted from prisons, jails, and state hospitals, and those covered under Proposition 36.
- **Adults with SMI and a substance abuse disorder** – This population is composed of adults who meet DMH criteria as having an SMI who also have a substance abuse problem that exacerbates symptoms, interferes with recovery, or causes unplanned readmissions to treatment.
- **Children and youth with SED and a substance abuse disorder** – This population is made up of children, adolescents, and young people (age 18 – 21) with a substance abuse problem who meet DMH criteria as having an SED, particularly youth who are transitioning from foster care or juvenile justice systems, or moving from treatment systems for children to treatment systems for adults.

SPECIFIC RECOMMENDATION:
- Statewide efforts to coordinate/integrate treatment and support systems should target the identified focal populations
- State efforts should focus first on removing barriers to providing coordinated/integrated care and then on delivering more effective, better coordinated treatment services and support
- Specific strategies will differ due to eligibility requirements as well as differences in approaches to meeting the needs of each group, each sub-population, and/or each person

SPECIFIC RECOMMENDATION: The statewide effort to improve services for persons with co-occurring disorders should begin with these five focal population groups at the least. At the state and county levels, services provided by AOD, MH, health care, criminal justice, social services departments, and local interagency bodies such as the Continuum of Care services for people who are homeless, should be geared toward collaborative efforts to address the needs of these co-occurring disorders population groups. Some of these focal populations, and the culturally and racially diverse individuals who participate within them, are especially vulnerable and have particularly complex needs. The task is challenging. Current fragmented approaches consume much public and personal time, energy, and resources that could be better coordinated and produce improved outcomes. Adequate funding is required to support needed treatment aligned with best practices, which move in the direction of the coordinated/integrated approach to services described in this report.

SPECIFIC RECOMMENDATION: Statewide efforts to coordinate/integrate treatment and support systems should target these identified focal populations. State efforts to align funding and enact administrative changes should focus first on removing barriers to providing coordinated/integrated care and then on delivering more effective, better-coordinated treatment services and support for each of these groups of individuals. Specific strategies selected will differ due to varying eligibility requirements for categorical funding, as well as

differences in approaches to meeting the needs of each group, each subpopulation, and/or each person.

Identify and Pursue Funding Alternatives

In formulating its recommendations, the COD Workgroup recognized that the ability to change treatment practices and increase the availability of services based on evidence-based and promising practices is limited without significant changes in the provisions that currently govern the allocation and administration of public funding for treatment and services to persons with co-occurring disorders.

The COD Workgroup was also guided by its recognition of the following factors:

1. **Funding for treatment of substance abuse and mental health disorders and related health conditions in California and elsewhere is highly fragmented, with a multitude of programs administered by different public agencies, and often, different levels of government. Many funders have distinct, even conflicting requirements for serving individuals with substance abuse and mental health disorders. Conflicts need to be identified and managed through legislative changes or other approaches such as waivers.**

   Potential and current sources of funding include: Medicaid, the Substance Abuse Prevention and Treatment Block Grant, the Community Mental Health Services Block Grant, CalWORKs, Temporary Assistance for Needy Families (TANF), state and county tax revenues, the United States Department of Veterans Affairs (VA), and other federal grants which may be allocated to the State, local governments, or directly to nonprofit providers. Many of these funding streams currently have inconsistent or conflicting provisions regarding covered services; client eligibility and priority target populations; provider qualifications; allowable settings for service delivery; data and reporting requirements; reimbursement; and cost-sharing among and between state, county, and local governments. Some of these differences are based on categorical restrictions in federal or state law, while others are based on differences in organizational cultures, values, and habits. Accessing these funding sources may require identifying and successfully requesting waivers from relevant funding agencies.

2. **Many of the much-needed resources, such as Medi-Cal that are potentially available for treatment and support for persons with co-occurring disorders are obviously not under the direct control of ADP, DMH, or county departments of AOD or MH services. Financing and implementing effective responses to co-occurring disorders require coordination not only between departments of AOD and MH services, but also with agencies responsible for other services oriented to practical personal outcomes significant to recovery such as health services, job training, child welfare, criminal justice, housing and homeless services, and others.** While, as noted in the text above, there have previously been efforts in California to strengthen interagency partnerships at the state and local levels, as in the implementation of CalWORKs, which provided opportunities for

more flexible funding to serve parents with co-occurring disorders, and some targeted initiatives focused on children, these efforts have not been as thorough and systematic as needed.

The COD Workgroup believes that too often there is a lack of coordination and sometimes competition or conflict among agencies in administering funding. This results in fragmentation in the delivery of services to persons with co-occurring disorders and unnecessary expenditures of time and money for California's fragile budget. Providers seeking to establish multi-disciplinary teams for persons with co-occurring disorders report that they often find it difficult to access categorical resources from public programs or grants for services; requirements are often poorly coordinated or in direct conflict.

3. **There are very significant, avoidable costs when persons with co-occurring disorders are unable to access coordinated and effective treatment and support services. These include costs to the state and federal government, counties, cities, the individuals, families, neighbors, and California's businesses for treating repeated, sometimes duplicative and costly crisis episodes, including care in emergency rooms, psychiatric hospitals, detoxification facilities, or jails and prisons.** In addition, many people with co-occurring disorders, who have not been receiving coordinated/integrated treatment, are engaged only episodically and in crises with the county-administered AOD or MH treatment or support systems, but also do receive often costly treatment or support services in other settings as well, including state or local hospitals or health clinics, VA facilities and programs, employment programs, homeless assistance programs, child welfare services, and jails and prisons. Coordinating care and supporting individuals across these service systems is difficult but necessary. SAMHSA has done a study of state Medicaid and other databases that has shown that with some effort, such cross-system data integration is possible and useful and can serve as a basis for care coordination as well as for measuring outcomes for focal individuals across systems.[5]

4. **In the short term, California's budget crises will make it difficult to pursue recommendations that would require additional funding from state or local tax revenues. Based on its assessment, the COD Workgroup recommends that increased funding potential may be realized by using current resources more effectively, making investments that can promptly achieve offsetting savings and permit reinvestment of existing funds, streamlining and coordinating the allocation of existing resources, pursuing additional federal funding, where appropriate, even more vigorously than in the past, and using available federal and other funding as a catalyst to develop innovative local programs.**

The COD Workgroup began the process of identifying the costs associated with the limited capacity, gaps, and ineffective practices in the existing treatment systems for each of the focal populations identified in this report. The group identified significant avoidable costs that arise when persons with co-occurring disorders are unable to access the recommended effective coordinated treatments and support. As noted above, these can include excessive and avoidable public costs associated with frequent inefficient emergency room visits; ambulance

charges, and unnecessary and undesired hospitalization or readmissions for medical and psychiatric crisis; recidivism in jails and prisons or juvenile detention units; and repeated use of child welfare and foster care funds and emergency shelter and services that must be targeted to affected homeless individuals and families. In addition, individuals, their families, and communities bear substantial excess public safety and health care costs related to individuals using episodic services that cannot produce good outcomes because they are inadequate emergency oriented, not timely and/or ineffective in addressing long-term needs of co-occurring disorders clients.

The COD Workgroup began the task of formulating recommendations for funding strategies for each of the focal populations identified in this report. This report contains a partial list of these recommendations. The group did not have sufficient access to the staff from some state agencies[6] with appropriate technical expertise or authority to guide the formulation of more detailed recommendations or to explore the feasibility of every funding alternative identified; therefore, verification and amplification of these possible approaches is necessary.

The COD Workgroup further cautions that the participation of these key state agency staff and access to decision-makers will be essential if the recommendations contained in this report are to lead to meaningful actions and results. While it is difficult to make dramatic progress in today's fiscal climate, it is important to begin the technical analysis and planning that can lay the groundwork for reorganizing services and funding in future years.[7] It is equally, if not more important to begin to measure the increasing and avoidable costs of maintaining the ineffective status quo – the wasted resources associated with revolving-door crisis care, and human and social impact in California when persons with co-occurring disorders are unable to access the care they need and consequently continue to deteriorate unchecked.

...participation of these key state agency staff and access to decision-makers will be essential if the recommendations contained in this report are to lead to meaningful actions and results.

SPECIFIC RECOMMENDATION:
Request that the Legislative Analyst's Office, or other entity, conduct an analysis of the costs of co-occurring disorders, including excessive or potential avoidable costs and costs associated with meeting the needs of persons with co-occurring disorders.

While this report is being submitted to the Directors of ADP and DMH, some of these recommendations herein require action by these two state departments working in partnership with other state agencies, the Governor, the Legislature, counties and other local government agencies, and public and private agencies that currently use federal, state, or local government resources, as well as SAMHSA. As noted above, the good news is that some of the agencies in California have already begun to take concrete steps toward achieving some of the short-term recommendations contained in this report, possibly triggered in part by their participation in the COD Workgroup deliberations and by their dedication to saving and improving lives.

Also, as noted above, a complete description of public financing for the treatment systems and services for people with co-occurring disorders is beyond the scope of this report. Unfortunately there is no single, comprehensive and up-to-date description available that is focused on this growing population of vulnerable persons. Additional resource information on funding alternatives is listed in Appendix D.

SPECIFIC RECOMMENDATION: Request that the Legislative Analyst's Office, or other entity(ies) with similar stature and credibility, conduct an analysis of the costs of co-occurring disorders to the State or to local governments, particularly those that are attributable to the limited availability of effective treatment and support for the focal populations with co-occurring disorders. This analysis should measure excessive or potentially avoidable costs, including costs associated with responding to the needs of persons with co-occurring disorders. It is important to note that these excessive or potentially avoidable costs cannot be reduced by simply cutting spending in a budget line item. To achieve savings will require investments in more effective treatment and support in order to prevent or reduce the incidence of avoidable crises or recidivist use of costly emergency and institutional care.

These potentially avoidable costs should be examined in the following settings:

- State or county criminal justice systems, including jail or prison and courts.
- Homeless assistance programs.
- County or other "safety net" hospitals providing emergency room and inpatient care for medical problems that are preventable or are complicated by co-occurring disorders.
- Child welfare, protective services, foster care, and family courts.
- CalWORKs, including the impact of failure to comply with welfare-to-work program requirements.
- Inpatient psychiatric hospitalizations and other crisis care in AOD or MH treatment facilities, particularly for repeated emergencies.

SPECIFIC RECOMMENDATION: Establish an ongoing workgroup to explore further and determine more definitively the feasibility of funding opportunities identified by the COD Workgroup.

SPECIFIC RECOMMENDATION:
Establish an ongoing workgroup to further explore the feasibility of funding opportunities identified by the COD Workgroup.

- Staff from ADP and DMH, legislative fiscal committee staff, and personnel from other relevant public agencies[8] with the appropriate technical expertise and authority should be assigned to participate as full members in this workgroup, as well as including knowledgeable, diverse stakeholders representing focal populations and policy experts.
- The purpose of the workgroup will be to review and recommend revisions to federal and state funding requirements; identify opportunities to remove barriers to effective investment of existing funds; optimize federal and other funding; and identify possible new funding sources, including funding models used successfully in other states to address co-occurring disorders populations.
- The workgroup should develop guidance to support the coordination or "braiding" of funding from existing categorical programs at the local level to facilitate the implementation of multi-disciplinary teams to deliver coordinated/integrated services.[9] The workgroup should report regularly to the Directors of ADP and DMH, who will brief the Governor on progress toward streamlining the administration of categorical funding that can be used to provide treatment and support to persons with costly co-occurring disorders.
- The workgroup should continue work on innovative opportunities to increase federal funding and reimbursements, including the exploration of potential modifications to

California's State Plan for Medicaid Services. Revisions are needed to the definitions of medical necessity and covered benefits (which are currently used for some Medicaid benefits) to encompass needs for treatment, rehabilitation, and case management services to address co-occurring disorders consistently. The workgroup should review other State Plans for Medicaid Services and identify options for aligning benefits to provide more consistent definitions and administrative provisions which facilitate the delivery of services to persons with co-occurring disorders based on evidence-based and promising practices. The workgroup will also need to identify the potential costs and/or savings to the State and/or local governments associated with any changes in Medi-Cal-covered benefits, and to develop recommendations for financing these costs.

SPECIFIC RECOMMENDATION: Modify state and other funding provisions affecting California that create obstacles to using available resources and optimizing federal and other funding for effective services to the identified focal populations with co-occurring disorders:

- **Pregnant women and parents with co-occurring substance abuse and mental health problems**
  - ❑ *Review and identify opportunities for enhanced services through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Targeted Case Management (TCM), for children and adolescents whose parents reside in residential treatment for substance abuse or mental illness, or for services to homeless families and families living in supportive housing.* Identify opportunities to utilize benefits that are currently available but under-utilized to provide services that are effective for this focal population.
  - ❑ *Focus interagency workgroups on the needs of parents with co-occurring disorders.* Various forums and interagency workgroups have been established in state government to redesign child welfare services and to reduce or eliminate barriers to successful participation by families in welfare-to-work programs. As these groups formulate recommendations and implement new policies and programs, there should be a focus on providing targeted assistance to parents with co-occurring disorders.
  - ❑ *Persons otherwise eligible for CalWORKs who were convicted of drug-related felonies for use or possession should have access to income support, substance abuse treatment, and other CalWORKs services*.[10]
  - ❑ *ADP, DMH, and CDSS should collaborate with CADPAAC, CMHDA, and the County Welfare Directors Association to provide guidance and encouragement to counties to facilitate the use of CalWORKs resources in providing effective treatment and support services to parents with co-occurring disorders.* Counties should be encouraged to access CalWORKs flexible funding to provide coordinated/integrated treatment and support that may not be available in existing treatment programs.
  - ❑ *Use CalWORKs funding for treatment and support services linked to affordable housing for this focal population, particularly for homeless families.*
- **Indigent adults with co-occurring substance abuse and mental disorders who experience frequent or long-term health crisis or homelessness**
  - ❑ *Use federal funding opportunities to stimulate the development, expansion, dissemination, and replication of practices that produce positive outcomes and are effective in improving access to treatment and support for indigent adults with co-occurring disorders who are chronically homeless.* The federal government, including the United States Departments of Health and Human Services, Housing

and Urban Development, the VA, as well as the President's New Freedom Commission on Mental Health, and Congress, has made a commitment to end chronic homelessness within ten years. Many homeless individuals suffer from co-occurring disorders that contribute to or exacerbate their homelessness and general life risks associated with homelessness.

Federal funding was made available in 2003[11] to stimulate the development of new programs and interagency partnerships to achieve this goal, and additional federal resources are anticipated in 2004 and future years.

ADP and DMH should partner with other state agencies and local governments to pursue a systematic approach to aligning programs and policies to focus on solutions to homelessness for persons with co-occurring disorders. While most federal funding will be available to local governments and nonprofit agencies rather than to state agencies, there is an important role that can be played by ADP, DMH, and others. Staff should be designated to be responsible for gaining expertise and sharing information that will maximize the impact of federal policy and funding on expanding resources and improving outcomes for this focal population.

ADP and DMH should obtain, and disseminate to counties and municipalities, information about available federal resources and tools, including funding for programs that target persons with co-occurring disorders who are chronically homeless. ADP and DMH should encourage local applicants, by providing technical assistance and identifying promising practices as well as resources that can be used appropriately to meet grant match requirements. The Departments should convene grantees who obtain federal funding through these program initiatives, and consult with these grantees to identify effective practices, policy barriers and potential solutions, and financing strategies for sustainability. ADP and DMH should disseminate the results of these projects to support expansion and replication of effective models.

- *Review the recommendations that were adopted in 2002 by the Governor's Interagency Task Force on Homelessness and develop an action plan for pursuing the implementation of recommendations which will provide more cost-effective responses to the needs of homeless persons with co-occurring disorders.*
- *Explore options in consultation with the Centers for Medicare and Medicaid Services and assess funding strategies for an additional special Medicaid waiver that would provide Medicaid coverage for the co-occurring disorders/homeless population.* Identify legislative and regulatory changes that would improve access to Medicaid for persons in this focal population who are potentially eligible for Medicaid coverage but not enrolled due to homelessness. Increased outreach efforts and an expedited eligibility process should also be utilized.
- *Identify opportunities to improve access to SSI for persons with co-occurring disorders.* This should include sharing information with counties and Medicaid providers about funding opportunities and tools which have been made available by the federal government to improve access to SSI for chronically homeless persons. Identify local program initiatives that seek to increase access to SSI, and convene or consult with these programs to identify barriers that could be removed through changes or clarifications in state policies or procedures. Disseminate guidelines and

information about effective strategies for expediting and positively affecting SSI eligibility determinations.

- ❑ *Sustain and enhance the development of programs that are effective for this population, including integrated services for people who are homeless and mentally ill (Assembly Bill 2034, Chapter 518, Statutes of 2000 (AB 2034 Integrated Services Program)), and the Supportive Housing Initiative Act.*

- **Individuals involved with the criminal justice system who have co-occurring substance abuse and mental disorders**
  - ❑ *Working with CDC, develop procedures to access SSI and Medi-Cal benefits upon release from jail or prison.*[12]
  - ❑ *Explore the feasibility of using Medi-Cal Administrative Activity funding for pre-release activities that focus on restoring Medi-Cal benefits and ensuring continuity of care and appropriate housing for offenders as they return to community settings.*
  - ❑ *When funding permits, and as additional resources are available, expand definition of target populations with priority for mental health services to include individuals who are not SMI but who have a serious mental health problem that complicates addiction treatment.*

- **Adults with SMI and a substance abuse disorder**
  - ❑ *Review Medi-Cal and SSI funding requirements to identify opportunities for retroactive reimbursement for services provided to persons with co-occurring disorders while SSI eligibility is pending.* For this focal population, establishing SSI eligibility can be difficult, and may require up to two years of assessment, treatment, case management, and legal advocacy before SSI benefits are awarded and Medicaid eligibility can be established. While service providers may bill retroactively to the month of the SSI application, not all counties or providers appear to be aware of this opportunity. They may not understand the correct process or they may not be able to sustain provision of services pending funding. State requirements are not clearly articulated and may not be maximizing all opportunities present under federal law. The State should provide clear guidance to the counties and providers.
  - ❑ *Modify California's State Plan for Medicaid Services definitions of medical necessity and covered services to encompass the need for treatment, rehabilitation, and case management services which address co-occurring disorders consistently.* Modifications should lead to greater alignment among benefits and administrative procedures for services that address substance abuse or mental health problems, and should encourage accurate and prompt screening and assessment of both substance abuse and mental disorders. Changes should also facilitate reimbursement under the Rehabilitation Option, TCM Option, or other covered services for the delivery of services that effectively address co-occurring disorders in treatment programs, as well as in settings where people with co-occurring disorders live, work, socialize, and seek help.[13]
  - ❑ *Review and recommend changes to the Medi-Cal drug formulary to improve access to effective co-occurring disorders treatment medications, both for addictions and mental disorders.*

- **Children and youth with SED and a substance abuse disorder**
  - ❑ *Review and recommend opportunities for Medicaid reimbursement for enhanced services through EPSDT and TCM Option.* Identify options to utilize benefits that are currently available but under-utilized to provide services that are effective for this focal population.
  - ❑ *Focus interagency workgroups on the needs of transition-aged youth with co-occurring disorders.* Existing forums and interagency workgroups have been established in state government to address the needs of transition-aged youth. As these groups formulate recommendations and implement new policies and programs, there should be a specific focus on providing targeted assistance to children and youth with co-occurring disorders.
  - ❑ *Use CalWORKs or TANF funds to develop and implement services and support targeted to youth with co-occurring disorders who are leaving foster care at age 18, as a strategy for preventing teen pregnancies.*
  - ❑ *Provide services linked to affordable housing for young people with co-occurring disorders who are leaving foster care, and are at a high risk of homelessness.*

Develop and Implement a Training Plan

...develop a staff training plan with distinct action steps. This approach includes a Train-the-Trainers component to create a pool of teaching staff that can offer didactic presentations, skill practice sessions, supervision, and consultation around the state.

The COD Workgroup formed a Training Committee composed of three expert psychologists familiar with co-occurring disorders who have mapped out a staff training plan with distinct action steps. This approach includes a Train-the-Trainers component to create a pool of teaching staff that can offer didactic presentations, skill practice sessions, supervision, and consultation around the state. When possible, training activities should be synchronized with changes in other related areas, such as endorsement of integrated assessment for co-occurring disorders at program sites, staff evaluation on the basis of increasing proficiency in addressing co-occurring disorders, and other systemic elements that reinforce new skill acquisition. Public recognition of staff progress and achievement should be encouraged. The COD Workgroup also reviewed and endorsed the training plan proposal included in Appendix B of this report.

SPECIFIC RECOMMENDATION: ADP and DMH establish a statewide Training Committee, with membership selected by ADP and DMH and staff support from both departments, and recognize the strength of California professionals who could be called upon to participate on the committee and provide training. The Training Committee would:

- Focus on the development of an infrastructure that provides ongoing education to direct-care staff and administrators on promising and/or EBPs.
- Develop a Statewide Training Plan targeting service delivery and strategies for coordinating county operations between AOD and MH.
  - ❑ The Training Plan should include input from stakeholders at the state, county, and provider level and should address both service delivery and operational coordination.

Service delivery encompasses best practice models to ensure persons with co-occurring disorders receive necessary services and support. Operational coordination training identifies the lead and supporting roles of the various agencies and payment sources and responsibilities.

- ❑ The Training Plan should consider use of a Train-the-Trainers approach, identifying the method of recruiting and electing trainers; revising and enhancing the curriculum; and delivering, evaluating, and perpetuating training.
- ❑ The development and implementation of the Training Plan should facilitate integration with those systems which serve persons with co-occurring disorders, including criminal justice, social services, child welfare, welfare-to-work, housing, and continuum of care (homeless services).

- Review the Co-Morbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS) or other provider self-assessment. The COMPASS tool or other selected provider assessment tools should be well-publicized and available to counties and providers on ADP and DMH Web sites.
- Oversee the development of services and operational coordination training modules, possibly using a Train-the-Trainers strategy.
- Identify potential funding sources to support training, including the Pacific Southwest Addiction Technology Transfer Center, SAMHSA's Center for Mental Health Services (CMHS) Training and Evaluation Grants, and SAMHSA Co-Occurring State Incentive Grant.
- Work with counties willing to voluntarily set aside training funds.
- Identify opportunities for training and education requirements related to co-occurring disorders for professionals including marriage and family counselors, psychologists, and other helping professionals.
- Develop executive briefings on existing and new practices and strategies for funding and implementing evidence-based programs; and provide information on training opportunities at the federal, state, and local levels. These executive briefings should be made available to the field directly and be posted on the ADP and DMH Web sites.

Develop Standards for Program Licensing and Site Certification that Address the Needs of Individuals with Co-Occurring Disorders

California currently lacks an overall framework for specialized program licensing and site certification for the array of services noted above that are needed to address co-occurring disorders. Current licensing and site certification standards do not establish any provision for services specific to a client with co-occurring disorders. Programs serving this population may come under the administrative responsibility of several state departments including ADP, DMH, DHS, the Community Care Licensing (CCL) Division of CDSS, and other state agencies which may have overlapping or conflicting requirements. Some current state site requirements are applicable to residential programs or outpatient treatment program facilities; others are applicable to providers who seek Medi-Cal reimbursement for services. Some types of services or service settings do not require licensure or certification, while in other cases requirements are ambiguous.

Clear standards, guidelines, and/or exemptions have not yet been developed for the complex service strategies that are effective in serving persons with co-occurring disorders, particularly services delivered outside of inpatient or residential treatment facilities. The lack of such a framework may create obstacles to the effective use of federal grant funding, which may be restricted to programs that are licensed or certified or clearly exempt from such requirements under applicable state law.

ADP and DMH need to develop jointly a set of program licensing and site certification categories, or other standards for programs that are exempt from licensing, which are appropriate to treatment programs that provide comprehensive services for clients with co-occurring disorders. It is preferable to provide these services either at a single site or through a single interagency team that may deliver services in a range of community settings. In either case, careful coordination of services is essential.

SPECIFIC RECOMMENDATION:
- Establish a group of licensing and certification experts from all relevant state departments.
- New program licensing and site certification standard should draw upon the documentation of effective practices recognized by SAMHSA.

Although it may be desirable to have a single set of program licensing or site certification requirements for all treatment programs, this goal can only be achieved in incremental steps. At present, most MH treatment programs serve those with severe and persistent mental illness, including those who also have co-occurring disorders, whether recognized or not. Addiction treatment programs often serve clients with a wider range of mental disorders but programs are generally not equipped to handle clients with severe thought disorders or who are actively psychotic. Both categories of programs are important to the community and the focal populations but need to be clearly distinguished for those seeking services.

SPECIFIC RECOMMENDATION: Establishment of a group of licensing and certification experts from all relevant state departments, including ADP, DMH, CDSS CCL Division, and DHS, as well as the Department of Housing and Community Development, together with providers, to address the following:

- Articulation of a comprehensive framework for program licensing and site certification, and/or standards for programs that are exempt from these requirements, to address the full range of program models with demonstrated effectiveness for persons with co-occurring disorders.
- Standards for addressing other mental disorders within substance abuse programs, with clear indications of whether the program can handle people with SMI.
- Clarification of the mechanisms for removing regulatory barriers that discourage providers from serving this population. Providers perceive regulatory barriers in the form of conflict between CCL licensing and ADP certification.
- Creation of incentives for the development of co-occurring disorders programs through adequate reimbursement, based on meeting co-occurring disorders licensing and site certification standards.

SPECIFIC RECOMMENDATION: New program licensing and site certification standards should draw upon the documentation of effective practices recognized by SAMHSA, and

described in this report's section on Effective Practices. These include SAMHSA's National Registry of Effective Programs, and the forthcoming SAMHSA Treatment Improvement Protocol for Co-Occurring Disorders.

Develop a Universal Chart

In the time allotted for COD Workgroup activities, consensus could not be reached on the complex issue of developing a universal chart format and a single audit protocol for treatment record documentation. However, Dr. Peter Banys of the San Francisco VA Medical Center, an authority on co-occurring disorders and substance abuse, has prepared a detailed description relevant to the development of a universal chart format. This description was valuable and insightful to the COD Workgroup and is included in its entirety in Appendix C.

Identify and Adopt Effective Practices

In recent years, there has been a major effort among leaders in the fields of substance abuse and mental health treatment to identify and document effective practices, based on objective information currently available from recognized experts and the scientific literature. These effective programs and practices have been identified by SAMHSA as "EBPs," "Promising Practices," "Emerging Best Practices," and "Model Programs."[14] The federal government, through SAMHSA, has worked with recognized experts, state and local agencies, advocacy organizations, providers, clients, and family members to identify a set of practices that have been well implemented and have consistently demonstrated a positive pattern of results.

As a major policy initiative related to this co-occurring disorders effort, SAMSHA has been promoting both "science to service" and "service to science" efforts. It has recently restructured its discretionary grant portfolio to give incentives to states to incorporate such practices into grant applications, as well as to provide funding for efforts that document and evaluate innovative and promising practices, particularly practices that can fill identified service gaps. SAMHSA now has Best Practices Planning and Implementation Grants (BPPI 04) available in 2004 to accomplish this goal. California should explore applying for these grants.

This initiative has also been coordinated with SAMHSA's National Registry of Effective Programs (NREP) now being put in place for all SAMHSA agencies. In addition, SAMHSA's Center for Substance Abuse Treatment (CSAT) has for many years published the CSAT Treatment Improvement Protocols which are consensus-based guidelines developed by clinical, research, and administrative experts in the field. CSAT sponsors other effective practice publications available from the Federal Department of Health and Human Services and SAMSHA's National Clearinghouse on Alcohol & Drug Information (NCADI); the National Institute on Drug Abuse (NIDA) publishes NIDA Manuals, also available from NCADI, that present best practices studies; and the National Institute on Alcohol Abuse and Alcoholism also publishes best practices studies. All of these publications serve as valuable models and reference points to address best

practices for co-occurring disorders populations and can also provide avenues for publishing and dissemination of best practices California develops for its co-occurring disorders populations.

In addition, a major initiative coordinated by the New Hampshire-Dartmouth Psychiatric Research Center and supported by both the Robert Wood Johnson Foundation and SAMHSA's CMHS has resulted in "toolkits" (implementation packages consisting of manuals, videotapes, and other implementation support materials) for six co-occurring disorders-relevant EBPs including:

1. Illness Management and Recovery
2. Family Psychoeducation
3. Medication Management Approaches in Psychiatry
4. Assertive Community Treatment
5. Supported Employment
6. Integrated Dual Disorders Treatment

The toolkits are currently being tested in eight states and contain information that could be used or adapted in a best-practice co-occurring disorders approach.

The COD Workgroup supports that efforts to promote the adoption of more effective practices for meeting the needs of people with co-occurring disorders in California should be consistent with these and similar national efforts while continuing to build the documentation and evidence base needed to support replication of effective programs that have been developed and implemented locally. Several effective pilot programs have recently been established in California to serve persons with co-occurring disorders. While some of these programs have received support or recognition from SAMHSA, additional efforts are needed to support the development, documentation, and evaluation necessary to facilitate the inclusion of these program models in NREP and recognition of them as models for expansion and replication. Examples of such programs include, but are not limited to, the following:[15]

- PROTOTYPES Women's Center
- AB 2034 Integrated Services Program
- Lamp Community
- Bonita House
- East Bay Community Recovery Project
- San Francisco VA Medical Center
- Ohlhoff Recovery Programs
- Walden House

California's consistency with and reporting on the approaches recognized by SAMHSA will ensure even more effective use of available research, and may provide opportunities to obtain further federal or foundation grant funding. These funding opportunities can strengthen and expand the capacity to provide model treatment and supportive services to persons with co-occurring disorders.

The COD Workgroup identified certain EBPs that have been utilized with a number of the co-occurring disorders focal populations described in this report. These practices come from both AOD and MH treatment systems. Programs that serve persons with co-occurring disorders

in either treatment system have generally adopted some elements of these well researched best practices.

Examples include, but are not limited to, the following:

Substance Abuse Treatment System	Mental Health Treatment System
Motivational Enhancement Therapy	Assertive Community Treatment
Cognitive – Behavioral Treatment (e.g., Seeking Safety Curriculum)	Intensive Case Management
Relapse Prevention	Medication Algorithms
Modified Therapeutic Communities	Multiple Systemic Therapy
Opioid Agonist Treatment (Methadone, Buprenorphine)	Cognitive Behavioral Treatment
Smoking Cessation (e.g., nicotine replacement therapies (patches, gum, lozenges, spray); CBT group support; and mediation (bupropion))	
Multiple Systemic Therapy	

Recognizing that consensus panels and expert opinion also constitute important levels of evidence, the COD Workgroup acknowledged these additional, co-occurring disorders-relevant practices and their ongoing efforts:

- Client and Family Member Involvement
- Supportive Housing
- Representative Payee/Money Management Services
- Jail Diversion and Community Re-entry Programs
- Trauma-Specific Interventions
- Wraparound Services
- Peer-Run/Peer Counseling Services

In addition to working closely with the SAMHSA best practices projects noted above, ADP and DMH can and should take advantage of and participate in the widely recognized "best practices in behavioral health performance management work" being done by The Washington Circle ® for substance abuse measures, funded by CSAT and the Forum on Performance Management, funded jointly by CSAT and CMHS, which hold annual meetings at the Carter Center in Atlanta. These two initiatives, founded with SAMHSA and involving two key members of The Avisa Group, one of whom is a COD Workgroup member, are focused on creating common sets of national performance indicators across substance abuse and mental health. Both initiatives attempt to create a common measurement platform across the public and private sectors for substance abuse and mental health. While the groups have not issued co-occurring performance measures yet, both groups may include such an effort in their upcoming annual plans.

Additional resource information on effective practices is listed in Appendix D.

Identify and Discontinue or Modify Ineffective Practices

The COD Workgroup decided that for co-occurring disorders treatment to work, it was as important to identify ineffective practices that should be discontinued or modified immediately as it was to identify effective ones. The COD Workgroup identified a number of existing practices that have been shown in the research and published policy studies to be relatively ineffective or of limited effectiveness. These should be identified, abandoned, or modified as soon as possible to improve the effectiveness of treatment services for persons with co-occurring disorders. Removing and replacing these ineffective practices in California is as critical to instituting effective practices as is developing new ones. Examples of practices that expert members of the COD Workgroup felt should be changed include, but are not limited to, the following:

- Requiring complete sobriety or abstinence as a pre-condition for access to MH treatment.
- Denying access to AOD treatment programs for persons who are using prescribed medications to treat mental disorders.
- Arbitrary prohibitions against the use of certain prescribed medications (e.g., psychotropic medications or opioid agonists).
- Requiring complete abstinence as the only possible goal for co-occurring disorders or substance abuse treatment of the co-occurring disorders population.
- Arbitrarily limiting access to detoxification (e.g., no more than once every three months) or other services without basis in scientific efficacy.
- Discharging clients from AOD or MH treatment without housing or other culturally appropriate support services, if needed.
- Mandated withdrawal from methadone as a goal of treatment.

SPECIFIC RECOMMENDATION: Departments should partner to support the adoption and expansion of effective practices and replace and abandon or modify ineffective practices based on the best available evidence and pursue available funding.

SPECIFIC RECOMMENDATION: ADP and DMH can and should partner to support the adoption and expansion of effective practices and the replacement, abandonment, or modification of ineffective practices based on the best available evidence, especially working to include clinical/other practices that are consistent with the evidence-based and promising practices already recognized by SAMHSA.

SPECIFIC RECOMMENDATION: ADP and DMH should pursue available grant funding through SAMHSA's Infrastructure Grants and/or Best Practices Planning and Implementation Grants or other sources to support the following activities:

- Continue identifying emerging EBPs for the focal populations and other co-occurring populations.
- Monitor implementation of EBPs in the state for accuracy and the need for new infrastructural components (e.g., clinical record systems).
- Educate providers, clients, and family members about the relative advantages of EBPs.
- Establish a statewide training committee to ensure that training and technical assistance needs are planned and implemented for EBPs.
- Identify obstacles to implementation of EBPs and provide guidance to move toward more effective implementation.

- Provide a central mechanism where the latest research related to EBPs can be obtained and implementation experienced with specific EBPs can be posted.

Specify and Use Public Sector Outcomes and Performance Measures

For the purposes of this report, the term "outcomes" refers to significant, practical, and policy-relevant changes in the lives of persons receiving coordinated/integrated co-occurring disorders treatment, resulting from having received these services. The definition of public sector outcomes as used in this report is a group of possible measures that provide a validation of why the public ought to continue to invest its resources in evidence-based substance abuse and mental health treatment activities.

SAMHSA has been a lead agency within the federal system in providing incentives to states, including California, for measuring substance abuse outcomes. From 1998 to 2002, California participated in a 19-state pilot study to develop and test an outcomes monitoring system for the AOD treatment field through the California Treatment Outcomes Project (CalTOP). The use of a standard assessment tool, the Addiction Severity Index, enabled providers to measure improvements in seven major life domains, including psychological/psychiatric. This allowed CalTOP measures to be relevant to the co-occurring disorder treatment population, in addition to other populations, such as perinatal and criminal justice, treated in the current system of care. ADP received funding to assist in the establishment of the California Outcomes Measurement System (CalOMS) which is a statewide client-based data collection and outcomes measurement system allowing ADP to effectively manage and improve the provision of AOD services at the state, county, and provider levels. CalOMS will generate the data needed to:

- Meet federal reporting requirements.
- Document prevention and treatment population demographics.
- Identify AOD trends and risks and other outcome indicators.

Practical measurement of public treatment outcomes requires continuously tracking clients enrolled in coordinated/integrated co-occurring disorders services, as opposed to looking at individuals' possible progress at the end of treatment or a year later. This "enrollment approach" is particularly suited to two of the focal populations identified by the COD Workgroup: adults with SMI and a substance abuse disorder, and indigent adults with co-occurring substance abuse and mental disorders who also experience frequent or long-term health crisis or homelessness. The "enrollment approach" is familiar to many California counties participating in the State's AB 2034 Integrated Services Program because it is the methodology used there.[16]

In the enrollment system, the client's status is recorded on objective real-time domains when he/she is enrolled in the program. Then whenever the enrolled client experiences a change in any of these domains, a Change of Status (COS) form is filled out and entered into the database. For example, if a client moves from a Board and Care facility into his/her own apartment, a Residential COS form is filled out documenting that change. If the client moves

back to the Board and Care facility two days later, another Residential COS is filled out again to document the client's return. Similarly, a Hospital COS form is filled out and entered into the database whenever a client is admitted to or discharged from the hospital. An Employment COS form is filled out and entered into the database whenever a member gets or loses a job.

There are two major advantages to specifying and using real-time objective quality of life outcomes measures gathered over time, such as those in AB 2034:

1. First, management and administrative staff have instant access to up-to-the-moment, policy-relevant information regarding the status of the clients in their programs.

2. It is possible to track the number of episodes and days that clients spend in particular statuses with ease not available in a snap-shot format. This gives a much greater amount of information regarding client patterns, both individually and in the aggregate.

The domains used in AB 2034 reflect areas that focus on an individual's quality of life, as well as areas that policymakers want to improve through the use of public dollars. More importantly, they reflect very closely what mental health clients and family members have so far stated are the areas that they want the treatment system to help them achieve.

An outcomes collection system like this has allowed AB 2034 and CalTOP programs to document dramatic decreases in incarceration, psychiatric hospitalization, and days spent homeless, and a dramatic increase in days employed. While some specific substance abuse outcomes remain to be added to those noted above, the system has worked well to document the useful outcomes of public investment in types of services often needed by clients with co-occurring disorders.

In addition, for co-occurring disorders programs, particularly those that are substance abuse treatment-based programs, urinalysis status drug testing – another continuous measure – adds an important mediating variable. For substance abuse clients, urine testing outcomes are strongly correlated with the more general outcomes of incarceration, housing, employment, etc. thus, if a client were not showing positive outcomes, it may be possible to demonstrate whether these outcomes were the result of continued drug use.

There is a national movement in business as well as in public health, substance abuse, and mental health to use other types of indicators to obtain accountability by measuring desired performance and thereby the effectiveness of investment. SAMHSA has provided small grants to selected states, including California, to improve data collection systems for performance measurement data that may eventually be useful in allocating and evaluating its block grant funds in substance abuse and mental health. This effort is a work in progress and measurements are still in development, but it is in tune with the emphasis of the current administration in Washington, DC. Within SAMHSA and its CSAT and CMHS centers, there are different initiatives regarding the use of Performance Partnership Grants and whether and how they will affect SAMHSA's allocation of block grants in the future. SAMHSA has also been experimenting with incentives to induce states to measure and report key performance indicators in order to be accountable and to demonstrate achievement of State Plan for Medicaid Services objectives in substance abuse and mental health.

California's co-occurring disorders efforts will benefit from being part of the voluntary reporting packages for both measurement efforts and they can best be coordinated with SAMHSA, CSAT, and CMHS input.

> ...the State and the public sector need to be held accountable to document that they deliver validated forms of care...

Examples of performance indicators that are currently being widely tested include:

- Percentage of mental health agency clients identified with a substance abuse problem or severe dependence.
- Presence of service providers trained in co-occurring disorders treatment in substance abuse and in mental health agencies.
- Presence of successful billing and reimbursement for substance abuse treatment in a mental health agency.
- Presence of linkages with community advocacy groups.
- Accessibility of peer counseling.
- Percentage of substance abuse agency clients with a diagnosed mental health problem.
- Presence of successful billing and reimbursement for mental health services in a substance abuse agency.
- Percentage of programs within a county accepting referrals of co-occurring disorders clients and subsequently serving those clients.

The caveat for all measures noted above is that they may not be equally relevant for all the focal populations noted here and they may be in need of adjustment for children and adolescents, as well as California's many large and diverse populations.

SPECIFIC RECOMMENDATION: In concert with federal agency guidelines and ongoing initiatives, the State and public sector need to be held accountable to document that they deliver validated forms of care, as evidenced by meaningful mental health and substance-related outcomes data gathering efforts specific to the co-occurring population.

NEXT STEPS

Given the State's current fiscal environment and the imperative need to implement improvement in services provided to those with co-occurring disorders by reinventing service approaches in line with best practices, the immediate next steps that the COD Workgroup recommends to APD and DMH are the following:

- To expeditiously issue the interagency joint policy statement to confirm the Departments' commitment to working cooperatively and collaboratively to reduce administrative barriers and support coordinated/integrated services for clients with co-occurring disorders.

- Having received extensive feedback from SAMHSA on the previous application, California should re-apply for a Co-occurring Disorders State Incentive Grant, demonstrating that it continues to focus on the growing prevalence of co-occurring disorders. The strong collaboration demonstrated by this COD Workgroup, the continued focus of the members and the Departments on providing effective services to the diverse populations that make up California, and the new administration in Sacramento can combine to produce a viable, competitive grant application in 2004.

- Continue to aggressively pursue other resource opportunities to provide funding to address both short-term and long-term recommendations.

APPENDICES AND NOTES

- Co-Occurring Disorders Workgroup Roster
- Proposed Training Plan
- The Universal Chart for Addiction and Mental Health Treatment by Peter Banys, M.D.
- Resources
- Notes

APPENDIX A: CO-OCCURRING DISORDERS WORKGROUP ROSTER

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APPENDIX B: TRAINING PLAN

California Department of Alcohol and Drug Programs
California Department of Mental Health

Co-Occurring Disorders Workgroup

ADP/DMH Statewide Training Committee

ACTION PLAN

SHORT OR LONG TERM	TASK AND SUBTASKS	RESPONSIBLE PARTY	DUE DATE	STATUS
Short	Establish Training Committee Appointed by DADP & DMH 6 members (Existing Members; county rep; additional members; ad hoc members (ATPC) Oversee implementation of the action plan	DADP DMH	Year 1	
Short	Establish section on web sites to provide information, dates, etc on training	DADP DMH	Year 1	
	FUNDING STRATEGIES			
Short	Apply for SAMHSA Grant Funds CMHS Training & Evaluation Grant SAMHSA COSIG Grant	Training Committee; State Departments	Year 1	CMHS - Completed 3/25/03 COSIG not approved 10/03
Short	Identify ATTC participation/contribution	ATTC	Year 1	
Short	Apply for additional SAMHSA TA funds		Year 1	
Mid	Set aside a portion of the SAMHSA state block grant for COD training	COD TF Recommendation; State Departments; CMHPC	Year 1	
Mid	Request counties to set aside a portion of training budgets for COD training (Small counties MH pool)	Training Committee; CMHDA; CADPAAC	Year 1	
Mid	Apply for Foundation Funding Identify potential funders (Schwab; TCWF; TCE, etc.) Request state depts. To establish fund, $25,000 each, for grant writing Submit grants	COD TF; Training Committee; State Departments	Year 1	
Long	Develop legislation to support on-going training efforts	Training Committee; CMHDA; CADPAAC	Year 1	

SHORT OR LONG TERM	TASK AND SUBTASKS	RESPONSIBLE PARTY	DUE DATE	STATUS
	POLICY MAKERS-EXECUTIVE BRIEFINGS			
Short	Develop briefing papers: Task force findings and action plans Policy issues EBP	COD	Year 1	
Short	Strategic Planning at the Local Level Provide Strategic Planning Format Provide Training on Strategic Planning Multi-system Planning including mental health, AOD services, medical (hospital & emergency services), law enforcement (jail and probation) homeless/housing continuum of care providers, HIV services, etc	Training Committee	Year 1	
Short	Self Assessment Tools Evaluate potential tools (COMPASS) State to pay licensing fees Executive briefing to CMHDA, CAADPAC, CAADPE Incentive for counties/organizations to complete assessment and submit data – first priority to receive training Collect data for future training needs assessment	Training Committee	Year 1	
Short	Present at monthly meetings for CMHDA, CAADPAC, CAADPE	Training Committee	Year 1	
	CLINICAL SERVICES TRAINING			
Short	Select curriculum Target for training: clinicians and recovery specialists Goals: increase knowledge; increase skills; change attitudes Training should be strategically conducted in concert with structural changes; should reinforce and support such change Include focus on clinical skills for service integration including, assessment, treatment, recovery, medications Include focus on partnership skills to coordinate/integrate services and supports needed by people with COD As appropriate, include focus on skills for increased financing to support service integration As appropriate, include focus on changes to licensing, certification and other standards Incorporate SAMHSA project curriculum as appropriate (Co-occurring Women COD & Trauma Research; IDDT Resource Research Project; National Registry)	Training Committee	Year 1	

SHORT OR LONG TERM	TASK AND SUBTASKS	RESPONSIBLE PARTY	DUE DATE	STATUS
Short	Review plan w/county directors/administrators for support CMHDA CADPAAC CAADPE	COD	Year 1	
	EDUCATIONAL INSTITUTIONS			
Mid	Develop strategies to assist educational institutions and other agencies training/educating new providers in MH and AOD to enhance their curriculum for co-occurring disorders	Training Committee	Year 1	
Long	Continue consultation/TA to the educational institutions for enhancing their curricula	Training Committee	Years 2 & 3 and Ongoing	
	REGIONAL TRAINING - TRAIN THE TRAINERS-FIRST YEAR			
Short	County Directors/Administrators identify trainers (for TOT) Criteria: Capable of teaching/training Have clinical experience Commitment from administration to do training 6 days a year	Training Committee	Year 1	
Short	Design training	Training Committee	Year 1	
Short	Apply for funding – SAMHSA etc	COD Task Force Members, State Depts.	Year 1	
Mid	Regional TOT training begins (2 - 6 regions)	Training Committee	Year 1	
Mid	Regional TOT training completed	Training Committee	Year 1	
	LOCAL TRAINING BY TOT			
Mid	Implement trainings in Counties by trainers who were trained	Training Committee	Years 2 & 3	

SHORT OR LONG TERM	TASK AND SUBTASKS	RESPONSIBLE PARTY	DUE DATE	STATUS
Mid	Develop an ongoing support structure for trainers An ongoing list serve to maintain contact with the new trainers and to provide an ongoing venue for discussion, questions, information dissemination Monthly conference calls/Web based interactive opportunities to address and discuss common issues; agendas developed around issues from the field and identification of EBP research findings; consultants used as needed. Twice yearly face-to-face training/consultation to continue development of skills and to add new trainers	Training Committee	Year 2	
	REGIONAL TRAINING TRAIN THE TRAINERS TWO TRACKS: NEW TOT & ADVANCED			
Long	Review and Update curriculum & trainers		Year 3	
Long	Review plan w/county directors/administrators for support CMHDA CADPAAC CAADPE		Year 3	
Long	County Directors/Administrators identify trainers (for TOT: advanced and new); update criteria		Year 3	
Long	Regional TOT training begins (2 - 6 regions)		Year 3	
Long	Regional TOT training completed		Year 3	
	LOCAL TRAINING BY TOT – SECOND CYCLE			
Long	Implement advanced trainings in Counties by trainers who were trained; implement new trainings in additional areas	Training Committee	Years 3 & 4	
Long	Ongoing Support structure continues, modified through continuous quality improvement	Training Committee	Ongoing	

APPENDIX C: THE UNIVERSAL CHART FOR ADDICTION AND MENTAL HEALTH TREATMENT

Peter Banys, M.D.
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In California, as elsewhere, there are numerous public funding streams that pay for addiction and mental health services, and their coverage does not currently sufficiently overlap for patients with co-occurring disorders. Federal payors include block grants, Medicare, VA, and Social Security; state payors include MediCal and Short-Doyle; and, counties and some cities pay for local emergency, residential, and hospital services for COD clients.

Each reimbursement system relies in part on records audits to control costs and verify appropriateness of services. Each payment system demands somewhat different information from the record for validation and reimbursement. The Workgroup believes that the funding cart is now driving the treatment horse. Diagnoses and descriptions of problems are skewed to reflect funding, needed services for co-occurring diagnoses are often not reimbursed, and public sector agencies are saddled with a Babel of incompatible charting, auditing, and reimbursement procedures that are very difficult to administer, much less to coordinate on behalf of COD clients.

In the case of COD clients with multiple diagnoses and problems, it has become fiscally prudent for treatment agencies to deliver and chart to the most reimbursable services. It is a fact that COD clients tend to receive services that are more determined by what treatment door they have entered than by their clinical needs. Moreover, overburdened public agencies turn away patients carrying the "wrong" diagnosis or problem description, in part to deal with the fact that they are overburdened and understaffed.

The Task Force recommends the development of a universal chart format that can be used in both mental health and addiction treatment systems in order to overcome some of these problems. The core elements of such a universal format include:

I. CPT Billing Codes
II. Problem-Oriented Records
III. Shared Dataset
IV. Computerized Client Record System (CCRS)

I. CPT Billing Codes:

Turning to a universal chart is a partial solution to the problem of skewed diagnoses and restricted services for complex COD clients. We conceptualize a universal chart as one in which services are reimbursed, not on the basis of any one diagnosis, but on the basis of the time-value of services delivered. Fortunately there is a model for such a system, and it is to be found in the federal Medicare system.

Medicare relies on Current Procedural Terminology Codes (CPT) for its billing/reimbursement algorithms. Generally speaking, clinical services are coded by complexity and/or time. In psychiatric and addiction services most CPT codes are based on (a) the nature of the service (for example, individual or group therapy), and (b) the length of service (in 15 minute increments). Physician services are sub-coded as E&M (Medical Evaluation & Management) services. CPT codes are then reimbursed according to standard dollar multipliers, or Relative Value Units (RVU's), that vary slightly from geographic region to geographic region. In somewhat oversimplified terms, CPT x RVU = Reimbursement. Complexity, service delivery time, and nature of the service drives the reimbursement, not the diagnosis *per se*.

II. Problem-Oriented Charting:

Since Larry Weed invented Problem-Oriented Charting in the late1960's, this method has been widely used in American healthcare and could be adopted and adapted for COD clients. There are two key components to Problem-Oriented Charts—(1) The Problem List, and (2) SOAP Progress Notes. A comparison of Dept. of Alcohol & Drugs charting requirements with Department of Mental Health (see Attachment, p. 43) charting requirements reveals no significant reasons that would stand in the way of adopting Problem Oriented Charting, although it will be a new approach and would require training behavioral health staff and providers.

The Problem List: Because the Problem List is not conceptualized as a list of diagnoses, providers can define presenting problems at whatever level they understand the presenting problem. In addiction treatment, for example, one does not necessarily know if a psychosis will prove to be primary schizophrenia or a disorder secondary to stimulant abuse, and depressive syndromes (often transient) are also ubiquitous in substance abusers. The items on a problem list evolve as clinical understanding develops. Whenever possible, problems should be listed as DSM-IV or ICD-9 diagnoses, but this is neither possible, nor particularly desirable too early in a client assessment.

NOS (Not Otherwise Specified) psychiatric diagnoses are often useful when diagnostic precision is not available. Psychosis NOS and Depressive Disorder NOS are useful placeholders as treaters try to sort out whether the psychiatric presentation is independent of or caused by drugs of abuse.

V-codes refer to problems that are ordinarily not reimbursed by payors as primary foci of treatment. However, V-codes are especially useful, even essential, in public sector populations, because so many initial presentations of patients are compounds of psychiatric disorders and social welfare or rehabilitation problems, and because certain kinds of non-diagnostic problems routinely require intervention. Some V-codes are noted below:

Health Maintenance	(V65.9)	Placeholder for charting to preventive measures such as PPD or HCV testing
Lack of Housing	(V60.0)	Housing/shelter placements
Legal Problems/Circumstances	(V62.5)	Court orders, domestic violence, DUI
Unemployment	(V62.0)	
Economic Problem	(V60.2)	Bus vouchers, GA benefits application

Marital Problem	(V61.1)	
Hi-Risk Sexual Behavior	(V69.2)	
Refusal of Treatment	(V62.6)	
Treatment Noncompliance	(V15.81)	Should be recurrent pattern

SOAP Notes: SOAP is an acronym *for Subjective, Objective, Assessment, and Plan*. *Subjective* refers to the patient's point of view. Generally this is stated in the patient's language. *Objective* refers to the clinician's point of view and to examination and laboratory data. *Assessment* refers to the clinician's opinion, inference and discussion. This is where syntheses of various data are made and where the case is formulated. *Assessment* refers to Diagnostic (Dx) elements such as further studies needed or further questions to be elucidated and to Therapeutic (Rx) elements such as medications, group therapy, or referrals for outside services. This is also the section in which providers discuss goals, responsible staff, and target dates.

It is not necessary to chart to each problem for each episode of charting. Notes are written when there is new information or significant negatives (And, alas, to satisfy regulatory requirements). Clinicians may group closely-related problems (Polysubstance Dependence) rather than list Alcohol Dependence, Cocaine Abuse and Prescription Analgesic Abuse separately. Problem oriented records do not endorse either "lumping" or "splitting" of problems, leaving that to clinician judgment. It is worth noting, however, that "Rule-Outs" are not problems. R/O Schizophrenia is not a problem, hallucination is the problem. R/O's are actually diagnostic plans to better figure out the nature of symptoms or syndromes.

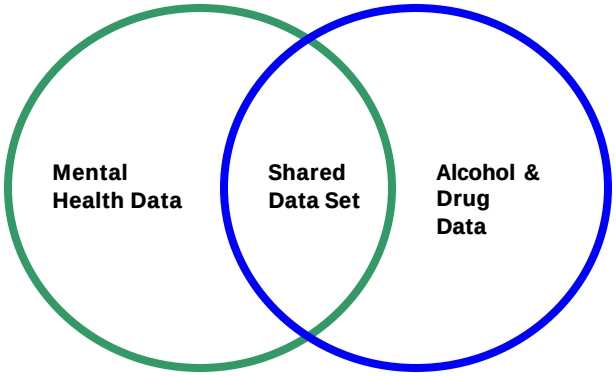
III. Shared Dataset:

There are two traditions in clinical charting that may be called "narrative" charting and "instrument" charting.

The older tradition of the two, narrative charting, basically retells the COD client's story utilizing a classical assessment format (Identifying Information, Chief Complaint, History of Present Illness and Problems). Recovery-oriented charting about step-work, denial, education classes and so forth is within this tradition. Narrative charting tells the patient's story, it focuses on the individual, and it guides patient-oriented treatment. The patient is human and recognizably so. Such notes communicate subtlety and nuance, and the responsibility for care is clear.

Instrument charting is newer and dependent on the development of validated clinical instruments or scales and on the ability of computers to analyze such data once it has been input. The CIWA-Ar and the COWS are two withdrawal scales with established validity that are attached on pp. 44-45. This newer component of charting has largely been driven by research (looking for outcomes) and by managed care (looking for efficiencies). Instrument charting measures data points over time, its focus is on cohorts of clients, and it guides program-oriented treatments. Information is numerically scaled and therefore affords assessments of change over time, databases provide continuity across multiple episodes of care, outcomes are measurable (as are acuity, severity, chronicity and recidivism).

Shared Data Set:
It is beyond the scope of this Workgroup to recommend a menu of instruments or information measures; however, the Workgroup strongly recommends the development of a common data set. We would like to see basic data, such as demographic information, formatted and collected in the same manner, possibly using the Objective Quality of Life instrument adapted for substance abuse as well as mental health (see Outcomes section of this Report).



In the modern era narratives and instruments are needed. So, it is important to note what addiction and mental health instruments are available today that show clinical and program utility.

IV. Computerized Client Record System (CCRS)

The Workgroup recognizes that at the present time public sector programs in California do not have adequate computer resources to move to fully electronic records. The first three recommendations (CPT Coding, Problem Oriented Records, and Shared Data Set) do not depend in any way on the implementation of computerized patient records.

However, we recommend that the Department of Alcohol & Drugs and the Department of Mental Health study adoption of programs like the value-added, open-source versions of VistA clinical records software developed by the Veterans Administration for public sector programs. VistA includes more than 50 separate but integrated modules, including the Computer Patient Record System (CPRS), an electronic medical record (EMR) system front-end. Several value-added vendors have taken VistA and ported it to Linux and Windows-based computer networks; generally speaking, they have added billing modules and other components necessary to run a healthcare enterprise in non-federal sectors.

Open-Source Software: Definitions of open source software may vary. It is not simply "free." The advantages of open source are well documented and include cost savings (no license fees), reliability/quality, and security. Since the source code is freely available, customers are also not (necessarily) "locked-in" to a single vendor. For a more complete definition of open source, please see http://www.opensource.org/docs/definition.php.

VistA[1]: VistA is a healthcare enterprise information system for both in- and out-patient services that is made available to the public through the Freedom of Information Act (FOIA) by the Veterans Health Administration (VHA), the largest, centrally directed, healthcare system in the U.S. It has been developed over 30 years by the Department of Veterans Affairs, the largest healthcare provider in the US, with 26 million patients as part of a single network. VistA currently manages all the clinical, financial, and administrative information needs of the VA's network of 170 hospitals and 1,300 total sites of care.

VistA includes a computerized problem list, progress notes modules that link CPT Codes and Diagnoses to each charted encounter. Other modules (if utilized) can provide computerized physician order entry, bar code medication administration, imaging, clinical modules, lab and pharmacy systems, and approximately 75 other modules. An easy-to-use, yet powerful graphical user interface allows healthcare providers to administer better care for their patients quickly and efficiently. VistA has gained an international reputation as a proven system with robust features and decades of software improvements.

[1] The Emerging Role of the Federal Government in Healthcare Information Technology, InfoHealth Management Corp., Sept 2003, http://www.infohealth.net/fsr/Vista_Infohealth_Part1.pdf

VistA Components:

Clinical Applications:

- **Clinical Modules (CM)**
  - Dietetics
  - Medicine
  - Mental Health
  - Nursing
  - Oncology
  - Prosthetics
  - Social Work
  - Surgery/Risk Assessment
  - Women's Health
  - Clinical Scheduling
- **Adverse Reaction Tracking**
- **Bar Code Medication Administration (BCMA)**
- **Imaging & Multimedia**
- **Computerized Patient Record System (CPRS)**
  - Clinical Reminders
  - Physician Order Entry (CPOE)
  - Consults/Request Tracking
  - Health Summary
- **Laboratory Management System (LMS)**
  - Anatomic Pathology
  - Blood Bank
- **Pharmacy Management System (PMS)**
  - National Drug File
  - Inpatient Pharmacy
  - Outpatient Pharmacy
- **Radiology/Nuclear Medicine**
- **Wireless Handheld Devices**

Financial & Administrative Applications:

- **Administrative and Personnel Scheduling**
- **Admission, Discharge and Transfer (ADT)**
- **Clinical Monitoring System**
- **Current Procedural Terminology (CPT)**
- **Diagnostic Related Group (DRG)**
- **Decision Support System (DSS) Extracts**
- **Integrated Billing**
- **Patient Information Management System**
- **Patient Identification Card System**
- **Supply Chain Management**

Open-Source Software Foundation:

- **Health Level Seven (HL7)**
- **Enterprise Email System**
- **Master Patient Index (MPI)**
- **Patient Data Exchange (PDE)**
- **Remote Procedure Call (RPC) Broker**
- **Database Management System**
- **Patch Stream Management System**
- **SQL Interface (SQLI)**

ATTACHMENTS:

Medical Record **Name:**..... **SSN:** ..... **DOB:**.....	**PROBLEM LIST**	**Agency** **Name** Street Address City, State ZIP *Tel. (NNN) nnn-nnnn*

Problem Number	Approx. Date of Onset	Date Problem Recorded	Active Problems	Inactive/Resolved Problems	Date Resolved
0			**Health Maintenance (V65.9)**		
			H/O IVDU, 1970's		
			S/P Appendectomy, 1955		
1	1968	07/14/01	**Alcohol Dependence (303.90)**		
			Antabuse (Disulfiram) trial, 8/13/01	D/C by pt. after 2 weeks	09/04/01
			H/O Delirium Tremens x 2		
2	1999	07/14/01	**Lack of Housing (V60.0)**		
		08/02/01	AMP Shelter		
		09/13/02	Treasure Island Housing	Discharged for ETOH	9/22/02
		03/05/03	Salvation Army Harbor Light		
3	1999	07/14/01	**Depressive Disorder NOS (311.0)**		
			H/O Recurrent SI and 5150 DTS hosp.		
		02/12/02	Prescription overdose, SFGH, 2/12/02	AMA Discharge	2/15/02
		11/15/03	Fluoxetine Rx Trial		
4	2002	11/15/02	**Low Back Pain (LBP)**		
		12/24/02	MRI lumbar study		
5	2002	02/12/03	**Legal Problem/s (V62.5)**		
		03/05/03	Domestic violence, probation to 2005		
		03/05/03	Court-ordered SA and anger Rx		
			Probation: Ray Smith (555-1234)		
6	2003	3/05/03	**Opioid Abuse (305.50)**		
			H/O Vicodin and Oxycontin drug-seeking and abuse (for LBP)		
		3/05/03	See Opioid Rx contract, 03/05/03		
7	2003	03/05/03	**Noncompliance with Treatment (V15.81)**		
			Repeat Acute Services, poor OP f/u		

Drug Medi-Cal (DMC)
Individual Patient Record Requirements

Abstracted and re-formatted from Title 22, California Code of Regulations. Section 51341.1(g)(1) lists specific requirements on the content of the individual patient record.

I. Admission/Intake/Assessment:

A. Demographic Information:

ODF/DCH/ Perinatal Residential modalities or NTP modality

1. Beneficiary identifier (name and patient ID number).
2. Date of birth.
3. Sex
4. Race or ethnic background.
5. Address and telephone number.
6. Next of kin or emergency contact.

B. History:

1. Personal History.
2. Medical History.
3. Substance Abuse History.

C. DSM Code

(Note that for DMC, the primary DSM code must a substance abuse diagnosis)

II. Requirements specific to Title 9

A. Medical & Substance Abuse History

B. Laboratory Tests

C. Physical Exam

Methadone Maintenance: Documentation of Physical dependence and addiction to opiates. Confirmed and documented history of at least two years of addiction to opiates. Confirmed history of at least two treatment failures Minimum age of 18. Certification of physical fitness for replacement narcotic therapy Evidence of observed signs of physical dependence.

D. Needs Assessment, including:

1. Psychological and sociological background
2. Educational and vocational experience
3. Health care
4. Employment
5. Education
6. Psychosocial
7. Vocational rehabilitation
8. Economic
9. Legal services

III. Treatment Planning

A. **ODF/DCH/ Perinatal Residential Modalities** treatment plans must include:

1. Statement of problems
2. Goals which address each problem
3. Action steps to be taken by patient and provider
4. Target dates to accomplish action steps and goals
5. A description of services, including counseling type and frequency The assignment of a primary counselor.

B. NTP modality treatment plans must include:

1. Needs identified in the assessment (statement of problems) Goals which address each need
2. Specific behavioral tasks to be completed by the patient
3. Type and frequency of counseling services
4. Effective date of the treatment plan
5. Progress or lack of progress toward each goal (update treatment plans)
6. New goals and tasks (update treatment plans)

IV. Progress Notes

A. ODF modality progress notes must include:

1. Description of beneficiary progress
2. Date of the counseling session
3. Duration of the counseling session
4. Type of counseling session (individual or group)

B. DCH/Perinatal Residential progress notes must include:

1. Time period covered by the note
2. Description of beneficiary progress
3. Date of the counseling session
4. Duration of the counseling session

C. NTP modality progress notes must include:

1. Date of the counseling session
2. Type of counseling format (individual, group or medical psychotherapy)
3. Duration of the counseling session in 10 minute increments
4. A summary of the session

CIWA-Ar: Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol

Patient:_____ **Date:** _____ **Time:** _____.(24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ **Blood pressure:**_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning ornumbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

 Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M.
Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**).
British Journal of Addiction 84:1353-1357, 1989.

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, *if* heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____SSN#: _____

Date and Time_____

Reason for this assessment: _____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	**GI Upset:** *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea *5* Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat ***on*** brow or face 4 Sweat streaming off face	**Tremor** *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sifting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated *5* Pupils so dilated that only the rim of the iris is visible	**Anxiety or irritability** 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms *5* Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	**Total Score** _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

APPENDIX D: RESOURCES

Funding Alternatives

The interim report of the President's New Freedom Commission on Mental Health provides an excellent description of the fragmentation in funding and administrative responsibility, and the impact of this fragmentation on the lives of people with mental illness, including those with co-occurring disorders. The report is available online at: www.mentalhealthcommission.gov.

A useful summary of California's financing and policy context for a broad range of treatment, health care, and support services was recently prepared by Deborah Kelch for the Frequent Users of Health Services Initiative (an initiative of the California Endowment and the California HealthCare Foundation). This report is available online at: http://documents.csh.org/documents/communications/fuhs/finalworkingdraft.legislative.PDF

A copy of DMH's Mental Health Plan is available upon request to: bholland@dmhhq@state.ca.us.

Effective Practices

SAMHSA's Model Programs Web site serves as a comprehensive resource for anyone interested in learning about and/or implementing these programs. Programs included have been reviewed by SAMHSA's National Registry of Effective Programs. The Web site address is: http://modelprograms.samhsa.gov/template.cfm?page=default.

A list of Evidence-Based Substance Abuse Treatment Practices established by SAMHSA's Center for Substance Abuse Treatment can be found at: www.samhsa.gov/grants/Public/BPPI_8_12.pdf

SAMHSA's report, "Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Substance Use Disorders" (December 2003), is available by contacting SAMHSA's National Mental Health Information Center at 1(800) 789-2647, or www.mentalhealth.org/publications/allpubs/SMA04-3870/default.asp.

Final Report of the President's New Freedom Commission on Mental Health, "Achieving the Promise: Transforming Mental Health Care in America," is available online at: www.mentalhealthcommission.gov

NOTES

[1] David Mee-Lee, M.D., a nationally-recognized clinical expert on co-occurring disorders, attended and early meeting of the COD Workgroup and provided information on initiatives in other states. Dr. Mee-Lee is Chair of the Criteria Committee of the American Society of addiction Medicine and Chair of the Coalition for National Clinical Criteria. He has consulted with many states on building clinical and administrative services for persons with co-occurring disorders. Since he had previously reviewed the COD Workgroup's Guiding Values document, he was able to provide input to the group and specific examples of efforts to implement programs in other states that reflected similar values.

[2] Stephen Mayberg, Ph.D., Director of DMH, served as a member of the Commission and members of the COD Workgroup provided invited testimony or other input into the deliberations of the Commission. The report recommends that "treatment for co-occurring disorders must be integrated", and the detailed findings and recommendations contained in the Commission's report are consistent with the findings and recommendations of the COD Workgroup.

[3] A detailed description of the COD Workgroup's goals and guiding values is available by contacting ADP's Program Operations Division, Assistant Deputy Director's Office, at (916) 324-5523, or Bill Holland, DMH's Systems of Care Division, at: bholland@dmhhq.state.ca.us.

[4] In particular, much of the empirical research that has validated treatment approaches for substance abuse or mental health has been based upon relatively homogenous populations that do not reflect the rich diversity of California's population. There has been limited participation in the most rigorous forms of research by persons with co-occurring disorders, women, people of color, and members of the focal populations identified by the COD Workgroup. There is a need to invest in documenting the effectiveness of treatment and service approaches that have been identified and recognized by a consensus of experts as "promising" or "emerging best practices." This reinforces the need of the COD Workgroup's goals relating to outcomes and performance measures.

[5] Since 1996, the federal Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) have been jointly funding a study and operationalization of an integrated database that cuts across Medicaid, Medicare, substance abuse, criminal justice, education, and employment to look at all facets of clients' utilization of public agency services. The National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors, and the Research Triangle Institute have been involved with Medstat (Rosanna Coffey, Ph.D.) in this ongoing set of studies slated to continue until 2006. The states of Delaware, Oklahoma, and Washington have been involved in this study, and have been successful in providing a possible information basis for comprehensive case management and other approaches for individuals with co-occurring disorders. The Integrated Database Project recently presented its results to date in a SAMHSA public session: "Data Integration: The Value of Using Mental Health with Data from Other Sources (December 4-5, 2003). The database provides an excellent model for California to begin collecting information to inform policy and enable coordinated/integrated service planning across public agencies.

[6] In particular, there was very limited participation by staff from DHS Medi-Cal (Medicaid) program. The federal Medicaid Program offers one of the few opportunities for increasing federal financial participation in paying for services for persons with co-occurring disorders, and some of the Medi-Cal benefits that could be better utilized are not under the administrative control of ADP and DMH. Full participation by DHS in future interdepartmental efforts to explore financing opportunities will be very important.

[7] The COD Workgroup recognizes that budget reductions in ADP and DMH may make it difficult to allocate staff to do this analysis or to implement some of the recommendations contained in this report in the short term. While recognizing the significant constraints imposed by recent budget reductions, the group recommends that this work should be considered a priority.

[8] Particularly DHS Medi-Cal program and CDSS CalWORKs and Child Welfare programs, as well as a representative from the Governor's Interagency Task Force on Homelessness.

[9] In developing this guidance, the workgroup should compile, build upon, and adapt any existing guidance that has been developed in conjunction with recent interagency efforts, such as the partnerships between ADP, DMH, and CDSS to facilitate the delivery of AOD and MH services to CalWORKs participants.

[10] The 1996 federal welfare reform law imposed a lifetime ban on TANF benefits for people with felony drug convictions for conduct after August 22, 1996 – regardless of their circumstances or subsequent efforts at rehabilitation – unless their state passes legislation to opt out of the ban. Although 31 other states have modified or eliminated the ban, efforts to enact legislation to make this change in California have been unsuccessful.

[11] More than $15 million in federal funding was awarded to new projects in San Francisco, Contra Costa County, and Los Angeles in October 2003.

[12] Since this recommendation was developed by the Workgroup, CDC has taken steps to facilitate SSI eligibility as part of the re-entry process. CDC has automated SSI forms into a database so caseworkers can complete the forms prior to the parolees' release. Working with the Social Security Administration, CDC is currently piloting the project in select areas across the state before implementing the new automated system statewide.

[13] As an example, the State of Georgia has adopted changes to its Medicaid Plan to provide a broad range of services covered under the Rehabilitation Option. The *State's Medicaid Community Mental Health Center Program Manual* establishes a consistent framework for authorizing and providing community services to persons with severe and persistent mental illness, co-occurring substance abuse and mental illness, and/or individuals with substance abuse issues who are eligible for Medicaid benefits. The Plan emphasizes the importance of consumers' natural environment, and allows for the delivery of services in the consumer's home, school, place of work and other locations, in addition to clinic or residential treatment program settings. For example, admission criteria for high intensity "Community Support – Team" services, which provide outreach and comprehensive, interdisciplinary, mobile, individualized services delivered in a range of settings, includes four or more of the following conditions:

- Two or more hospitalizations in past 18 months.
- History of inadequate follow-through with elements of a Treatment Plan related to risk factors (including lack of follow-through taking medications, following a crisis plan or maintaining housing).
- Intermittently medication refractory.
- Co-diagnosis of substance abuse (American Society of Addiction Medicine – any level of care).
- Legal issues (conditional release for non-violent offense; history of failures to show in court).
- Homelessness or at high risk of homelessness due to residential instability.
- Clinical evidence for suicidal gestures and/or ideation in past three months.
- Ongoing inappropriate public behavior in the community within the last three months.
- Self-harm or threats of harm to others within last year.
- Evidence of significant complications such as cognitive impairment, behavioral problems, or medical conditions.
- A lower level of care has been tried or considered and found inappropriate at the time.
- A lower level of care has been tried or considered and found inappropriate at this time.

[14] The difference between these terms is primarily based upon the extent to which the practices are supported by rigorous research and adequate documentation of effectiveness across a range of settings and target populations. A recent survey of state mental health agencies, conducted by the National Association of State Mental Health Program Directors Research Institute to assess the implementation of certain EBPs, indicated that all responding 49 states have implemented at least one EBP. The most commonly reported EBP was assertive community treatment, followed by supportive employment and integrated treatment for persons with co-occurring substance abuse and mental health disorders. At least 20 states are focused on implementing medication algorithms in schizophrenia.

[15] Program descriptions:

- **PROTOTYPES Women's Center** – Prototypes Women's Center in Pomona is a modified therapeutic community residential treatment program for women with substance abuse disorders, mental illness, trauma, HIV/AIDS, and other physical illnesses and their children. PROTOTYPES serves a diverse population: African American - 33 percent; Caucasian – 32 percent; Latina - 32 percent; Asian/Pacific Islander – 2 percent; and American Indian – 1 percent. Programs are up to 18 months in duration and contain a day treatment program and outpatient services. PROTOTYPES developed a model integrated treatment program for its clients that involves bringing together an organizational unit with a range of services delivered by one treatment team in a unified manner to improve outcomes for the client. Facility, medical staff, mental health staff, substance abuse treatment staff, vocational training staff, and children's staff plan and provide treatment and community re-entry. Services include: chemical dependency education; life skills building groups; individual, group, and family counseling; relapse prevention; and many other groups and training, such as onsite vocational training.

- **AB 2034 Integrated Services Program** – California's AB 2034 Integrated Services program has been recognized as a model for the delivery of comprehensive, individualized, and flexible services to adults who are homeless and mentally ill, and for enhancing partnerships between mental health, criminal justice, housing, and homeless service systems.
- **Lamp Community** – Nationally recognized for its community approach, Lamp Community is a Los Angeles nonprofit organization providing holistic, integrated housing, and support services for homeless men and women living with SMI. Established in 1985, Lamp Community has evolved into a safety net for homeless men and women who were formally without hope. They offer meals, housing, health recovery, job training, and other support services in nine facilities to over 4000 individuals annually.
- **Bonita House** – For over 30 years, Bonita House, Inc. has developed innovative approaches to the delivery of community-based care for adults with mental disabilities and substance use disorders and developed a national model for serving this population. Its oldest program site, the Residential Treatment Program (RTP), is one of the most important components of Alameda County's continuum of services for adults with co-occurring disorders. The Dual Diagnosis RTP opened in 1971; and since 1991, the program has exclusively served persons with co-occurring disorders. The Dual Diagnosis RTP plays a critical role in the County's efforts to serve adults with co-occurring disorders, as it is the critical bridge between acute care facilities and the less structured services offered through the Supported Independent Living program.
- **East Bay Community Recovery Project (EBCRP)** – This project has been in existence since 1989. The agency's focus has always been substance abuse treatment with difficult to serve populations; and very early on it recognized the connection between substance abuse and mental health, poverty, homelessness, trauma, domestic violence, unemployment, physical health, and criminal justice involvement. EBCRP operates both outpatient and residential programs using a modified therapeutic community model. The treatment model includes onsite case management, substance abuse and mental health counseling, specialized trauma and Post Traumatic Stress Disorder treatment, HIV/Hepatitis C services, psychiatry, acupuncture, and extensive collaborations with other service organizations. The residential program provides long-term treatment for pregnant and parenting substance abusing women, including one or more children. EBCRP is a model program with virtually all of its clients having co-occurring psychiatric and/or medical disorders.
- **San Francisco VA Medical Center** – The substance abuse programs are organized under a Phase Model of Recovery developed by Peter Banys, M.D. Co-occurring disorders are treated in an integrated manner along with addictions, and many clients require antidepressant or neuroleptic medication in addition to psychosocial treatment. There are also special programs to treat: (1) concomitant Post Traumatic Stress Disorder and addiction, (2) anger management problems, and (3) heroin dependence via an opioid agonist program. Psychiatric and addictive disorders are charted in a fully electronic medical record shared by the entire medical center. This record emphasizes the use of Problem-Oriented Charting. The San Francisco VA Medical Center programs are full research partners in two NIDA-sponsored Centers: the University of California San Francisco Treatment Research Center and the California-Arizona Node of the NIDA Clinical Trials Network.

- **Ohlhoff Recovery Programs** – Ohlhoff Recovery Programs is a nonprofit, community-based substance abuse treatment agency in San Francisco and Marin County. It offers a sliding scale and an array of services: primary residential, extended residential treatment, and intensive outpatient psychosocial care. The program emphasizes the need for clients to return to the workplace and is well-known for providing sophisticated assessments and treatments for co-occurring disorders in adults and adolescents.
- **Walden House** – Walden House has day treatment and residential treatment programs for clients with co-occurring disorders and has a multiple diagnosis program for clients who are HIV positive. Walden House programs integrate formal MH services with the therapeutic community approach. The Walden House Mental Health Department assesses clients with multiple diagnoses and then provides bio-psychosocial interventions as needed. A team of consulting psychiatrists evaluate, prescribe, and monitor medications and clients receive individual therapy, group therapy, and family therapy. Specialty psychotherapy groups address clients' specific issues that contribute to addition.

[16] This approach, as used in the AB 2034 program, may be described as:

- While there are many types of outcome measures, the effectiveness of integrated service programs is best evaluated by measuring objective quality of life (OQOL) outcomes, as opposed to clients' perceived self-improvement.
- Examples of OQOL measures are indicators of client status in the practical areas of residence; employment; education; criminal activity or avoidance of incarceration; income; and control over one's own life, such as conservator/payee; strengthening of a person's social supports; and physical health.
- Outcomes must be relevant to management, direct service staff, clients, policymakers, regulators, and funding sources.
- When possible, outcomes should be real-time rather than "snap-shot."
- Although all types of outcomes are important, when limited resources force us to choose between different types of outcomes, emphasis should be placed on outcome types in the following descending order of priority: quality of life, functioning, adverse impact, and clinical symptomatology.